DOCUMENT RESUME

ED 324 858 EC 232 403

AUTHOR Ronnau, John; And Others
TITLE Resource Training Manual for Family Advocacy Case Management with Adolescents with Emotional Disabilities.
INSTITUTION Kansas Univ., Lawrence. School of Social Welfare.
SPONS AGENCY Kansas State Dept. of Social and Rehabilitation Services, Topeka. Div. of Mental Health Services.
PUB DATE Jul 88
NOTE 154p.; For the companion manual, see EC 232 404. Print quality of appended materials is variable.
AVAILABLE FROM John Poertner, Twente Hall, School of Social Welfare, University of Kansas, Lawrence, KS 66045 ($10.00).
PUB TYPE Guides - Classroom Use - Guides (For Teachers) (052) -- Tests/Evaluation Instruments (160)

EDRS PRICE MF01/PC07 Plus Postage.
DESCRIPTORS Adolescents; *Child Advocacy; Counseling; Delivery Systems; *Emotional Disturbances; *Evaluation; Family Environment; Family Life; *Intervention; Models; Postsecondary Education; Social Workers; Staff Role; *Teaching Methods
IDENTIFIERS *Case Management

ABSTRACT

This training manual for social work practitioners is based on the Family Advocacy Model of Case Management, which states that case management with adolescents contains two important elements: work with the adolescent and work with those responsible for his/her care. This manual deals with the first of two elements and is designed to be used in conjunction with the companion "Training Manual for Family Advocacy In-Home Services," which explains work with adolescents' caregivers. The manual contains 19 units for trainees, each with objectives, activities, and background information. Units include, among others: description of the population to be served and the case management model; program objectives in terms of client outcomes, productivity measures, and staff morale; expectations of clients and case managers; role of the case manager; assessment through the life domains of family functioning; the goal setting process; action plans and monitoring; intervention strategies; the importance of relationship; affective involvement; key actors in the case management model; and making the most of group supervision. Appendices contain assessment tools (family's perspective form, collateral list and plan, youth's perspective form, and youth quality of life assessment); outcome monitoring tools (client contact record and goal planning form); client satisfaction measurement tool; staff morale tools (agenda for case discussions, worker's group supervision assessment, and supervisor's assessment of group supervision); a list of common characteristics exhibited by youth with emotional disabilities; and a statement of the educational rights of youth with emotional disabilities. Includes 17 references. (JDD)

THE UNIVERSITY OF KANSAS
SCHOOL OF SOCIAL WELFARE

ED324858

RESOURCE TRAINING MANUAL FOR
FAMILY ADVOCACY CASE MANAGEMENT WITH
ADOLESCENTS WITH EMOTIONAL DISABILITIES

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

John Fantuzzo

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

EC233403

RESOURCE TRAINING MANUAL FOR FAMILY ADVOCACY CASE MANAGEMENT WITH ADOLESCENTS WITH EMOTIONAL DISABILITIES

Project Director

John Poertner

Authors

John Ronnau

Jennifer Rutter

Richard Donner

The University of Kansas
School of Social Welfare
Twente Hall
Lawrence, Kansas 66045-2510
(913) 864-4720

July, 1988

The development of this training manual was partially supported by a grant from the Division of Mental Health Services, Social and Rehabilitation Services, State of Kansas.

TABLE OF CONTENTS

		Page
Introduction		
Unit 1	The Problem to be Addressed	1
Unit 2	The Population to be Served: Adolescents with Emotional Disabilities	6
Unit 3	Theory of Intervention: The Family Advocacy Case Management Model	9
Unit 4	The Goal of the The Family Advocacy Case Management Model	15
Unit 5	Program Objectives	17
	Client Outcomes	18
	Productivity Measures	19
	Staff Morale	19
Unit 6	Expectations of Clients and Case Managers	20
Unit 7	What the Case Manager Really Does	23
Unit 8	Assessment Through the Life Domains of Family Functioning	28
Unit 9	The Goal Setting Process	32
Unit 10	Action Plans and Monitoring	38
Unit 11	Intervention Strategies	43
Unit 12	The Importance of Relationship	50
Unit 13	Affective Involvement	53
Unit 14	The Setting for Program Implementation	57
Unit 15	Service Procedures	59
Unit 16	Assessment of Youth's Strengths and Needs	62
Unit 17	Key Actors in the Family Advocacy Case Management Model	65
Unit 18	Assessing and Developing Independent Living Skills	68
Unit 19	Making the Most of Group Supervision	72
	REFERENCES	

TABLE OF CONTENTS continued

APPENDICES

ASSESSMENT TOOLS:

-- Family's Perspective Form

-- Collateral List and Plan

-- Youth's Perspective Form

-- Youth Quality of Life Assessment

OUTCOME MONITORING TOOLS:

-- Client Contact Record

-- Goal Planning Form

CLIENT SATISFACTION MEASUREMENT TOOL

STAFF MORALE TOOLS:

-- Agenda for Case Discussions

-- Worker's Group Supervision Assessment

-- Supervisor's Assessment of Group Supervision

COMMON CHARACTERISTICS EXHIBITED BY
YOUTH WITH EMOTIONAL DISABILITIES

THE EDUCATIONAL RIGHTS OF
YOUTH WITH EMOTIONAL DISABILITIES

INTRODUCTION

This manual is based on the Family Advocacy Model of Case Management which states that case management with adolescents contains two important elements: the work with the adolescent and work with those deemed responsible for the youth. This manual details case management with the adolescent while the companion manual, *The Training Manual for Family Advocacy In-Home Services*, explains the work with the adolescent care-givers. It is important that these manuals be used in conjunction with one another.

This manual will begin with an explanation of the problem this program was designed to address and proceed with a description of the program itself.

UNIT 1

The Problem to be Addressed

Description: This unit presents the problem that case management with adolescents addresses. It describes the extent of, the contributing factors to, and the consequences of this problem.

Objectives:

1. Identify the problem that this case management model addresses.
2. Understand that emotional disabilities affect a significant number of adolescents.
3. Identify the major factors contributing to the problem.
4. Describe the consequences of ineffectively serving adolescents with emotional disabilities.

Activities:

1. Team members should begin the process of getting to know each other. The trainer should stress the close working relationship and cooperation required to make the program a success.
2. Trainees should be encouraged to express any anxieties or fears about working with individuals with emotional disabilities.
3. Discussion: The instructor should describe the continuum of care needed for adolescents with emotional disabilities, highlight the overuse of hospitalization for this population, as well as the limited community-based resources available. Trainees should discuss their ideas of the social work practitioner's role in overcoming these problems.

UNIT 1

The Problem to be Addressed

"Clearly, the mental health services currently available to children are inadequate, despite a substantial theoretical and research base suggesting that mental health interventions for children are effective," declared a report on children's mental health services issued to Congress in January, 1987, by the Office of Technology Assessment (Update, Winter 1986-87, p. 1). This background paper presented by OTA reflects the recent trend on both national and state levels to improve services for severely emotionally disturbed (SED) children and adolescents.

In 1984, in response to a federal mandate to improve services for children with emotional disturbances, Congress appropriated $1.5 million, resulting in the development of the Child and Adolescent Service System Program (CASSP). The appropriation for CASSP increased to $3.9 million by 1985, at which time 22 states had been awarded grants for the specific purpose of assessing their current services for these children, identifying service gaps and barriers, and developing programs to correct these problems.

Isaacs (1983) reports that while most "states programs have been focused on implementation at the local level . . . there has been planning and coordinative efforts at the state level" (p. 47-48). In addition, her review of five state programs to improve services for children with emotional disabilities suggests that states are beginning to target this population as a mental health priority.

This concentrated national effort to improve mental health services for children is a direct response to the simple fact that children with emotional disabilities are an ineffectively served population. According to Friedman (1984) "SED children are one of the most underidentified and underserved of the disabled populations" (p. 3).

Further compounding this problem is that those actually receiving services are not being adequately served. Children with emotional disabilities generally have a variety of needs. At best, most service delivery systems for this population are fragmented. The continuum of care needed to adequately serve these children simply does not exist. Without it, "children end up being served in more restrictive environments than they might otherwise need, often times the services are not in the child's immediate community, and consequently the family is not able to be as actively involved with the treatment as they should be" (Friedman, 1984).

Extent of the Problem

While prevalence estimates vary considerably due to the lack of one clear definition of severe emotional disturbance, in its description of CASSP the National Institute of Mental Health (NIMH) estimated that 3 million children suffer from this disability (Friedman, 1984). Knitzer (1982) is in agreement with NIMH, but states that this 5% estimate is conservative at best. More alarming, however, than the prevalence estimates is Knitzer's (1982) conclusion that "of the three million seriously disturbed children in this country, two thirds are not getting the services they need" (p. 3). Statistics from the U.S. Office of Special Education are that less than 12% of the estimated 3 million children with severe emotional disabilities were identified and served in the 1982-83 school year (Friedman, 1984). In addition, Friedman (1984) reported that, on the average, children's services receive less than one fourth of community mental health centers' resources.

Factors which Contribute to the Problem

Clearly, these children are ineffectively served. The question, then, becomes, why is it that children's mental health services are so obviously lacking? Two basic factors contributing to the problem are the definitional ambiguity of severe emotional disturbance and the diffuse accountability for this population.

While the Joint Commission on Mental Health of Children provided a general definition of an "emotionally disturbed child," the language is broad and standards for operationalizing the factors mentioned do not exist (Gilmore et al., 1984). A number of classification systems abound which, in a sense, also provide definitions of emotional disturbance. The problem remains, however, that no one system is completely satisfactory and, while the DSM III is the most commonly used classification system, it is possible for different service systems to use different classification systems.

Another aspect of definitional ambiguity is the arbitrary distinction between "severe" and "moderate" emotional disturbances, with a heavy reliance on "clinical judgment" (Friedman, 1984). Clinical judgment, however, is questionable in both the areas of reliability and validity. A child's classification, then, can not only change from service system to service system, but from service provider to service provider within the same service system, as well.

The consequences of this lack of clarity are great. Not only is it difficult for a child to obtain services from all the systems he/she may require, but also to receive adequate services when they are provided. In addition, "the definitional ambiguity helps make it possible for children clearly in need of specialized services to be overlooked" (Friedman, 1984, p. 18).

The second factor, diffuse accountability, has equally negative effects on the service delivery to these children. Generally, "there is no clear locus of responsibility for this group within the community" (Friedman, 1984, p. 24). While PL 94-142 was passed to help alleviate this problem by naming the educational system responsible for providing educational and related (i.e. psychiatric and counseling) services to all handicapped children, "there remains substantial confusion about whether the schools are in fact obligated to pay for psychotherapy or counseling" (Friedman, 1984, p. 24). While service systems are battling over who exactly is responsible for this population, these children are not being identified or receiving all the services they need.

Both definitional ambiguity and the diffuse accountability lead to a fragmented service delivery system. Communication between service systems is severely impaired by both of these factors causing a lack of continuity in providing services to children with emotional disabilities.

Consequences of the Problem

This fragmented service system takes its toll in a variety of ways. The losses incurred are felt by not only the child and the family but by society as well.

The incredible pain with which a child with an emotional disturbance lives must be experienced to be fully appreciated. The cost of inadequately serving, or perhaps not serving these children, is that approximately three million children live lives of confusion and unhappiness

The families, too, suffer. "Even if families stay together, the quality of life is diminished, the degree of human suffering is immeasurable, and the chances of reactive child abuse for any of the children in the family is very high" (Rodwell et al., 1985, p. 101).

The cost to society is also great. The loss is one of human potential, the most valuable resource our nation possesses.

More specifically, however, the consequences are felt by many social service agencies. While most mental illness may not be curable, providing adequate services to children may actually reduce their dependence on the social service system in adulthood. For example, "those in the adult mental health sector call for a variety of efforts in the children's field, which if successful, would lessen the scope of their problems" (Rodwell et al., 1985, p. 7).

State hospitals, in particular, bear the burden of inadequate children's services. They not only house children in need of their services, but many times children who may not need that restrictive an environment. Further, the lack of coordination among service systems often makes discharge difficult, resulting in hospital stays of a longer duration than is actually necessary. Consequently, these institutions are overcrowded and employee burnout rates are high.

It becomes apparent, then, that the improvement of children's services is not only desirable, but necessary. The Family Advocacy Model of Case Management has been designed to help alleviate some of the problems previously discussed. Before moving directly to the method of intervention, however, it may prove beneficial to examine the population served by this program.

UNIT 2

The Population to be Served: Adolescents with Emotional Disabilities

Description: This unit describes the target population this case management model was designed to serve.

Objectives:

1. To identify the five criteria used to define severely emotionally disturbed youth.
2. List the most common terminology and diagnoses used for these adolescents.
3. Understand the uniqueness of each adolescent client.

Activities:

1. Discussion - the instructor should lead the discussion on what the trainees expect these adolescents to be like and the kinds of behaviors they might exhibit.
2. Trainees should discuss their own adolescence; how they remember feeling and behaving.
3. Trainees should list ten things about themselves that they feel will be helpful in working with these adolescents.

UNIT 2

The Population to be Served: Adolescents with Emotional Disabilities

The criteria used to determine which youths will be served by this case management program are provided by the State Department of Mental Health and are as follows:

A child who:

1. Is under 18, or is under the age of 21 and has been receiving services prior to the age of 18 that must be continued for maximum therapeutic benefits;

2. Exhibits severe behavioral, emotional, or social disabilities that consequently disrupt the child's academic and developmental progress, family and/or interpersonal relationships, often to the point that the child is at risk for out of home placement, or is placed out of home;

3. Has disabilities that have continued for an extended period of time, or on the basis of specific diagnosis by a qualified professional are likely to continue for an extended period of time;

4. Has disabilities that cannot be attributed solely to intellectual, physical, or sensory deficits;

5. Frequently requires intensive treatment coordinated by an interdisciplinary team involving the family, courts, education, mental health and other family service agencies.

The standard mental health terminology used to describe the problems experienced by adolescents and children with emotional disabilities includes psychosis, severe depression, major difficulties at school or work, and severe impairment in forming and maintaining relationships. Overlaying these symptoms are patterns of chronicity, recurrence, and stressful family situations (Strauss, Downey, & Sledge, 1979; Lourie & Katz-Leavy, 1987). The Diagnostic and Statistical Manual of Disorders (DSM-III) diagnoses most commonly assigned to children and adolescents with severe emotional problems include: conduct disorders (unsocialized or aggressive types), anxiety disorders, schizoid disorders, developmental disorders, and schizophrenia (Norman, 1987).

While the above give the broad parameters of the characteristics of children with severe emotional problems, it does not actually prepare the case manager for the types

of individuals he/she will encounter. This task, in itself, is quite difficult. While these youths share the existence of an emotional disability, each child is unique. To illustrate this point, the following are examples of adolescent clients who might receive services through the case management program.

> Lisa is an attractive 13 year old residing on the adolescent unit at the state hospital. She is the only child of her 30 year old single mother with whom she lived before her admission to the ward. Lisa was placed in the hospital because of her frequent runaway attempts and her inability to respond to her mother's authority. She receives excellent grades in school and finds it easy to make and maintain friendships. She was diagnosed a Conduct Disorder by the attending psychiatrist. Lisa feels her problems stem from boredom. Her mother works and takes night classes and is seldom home. The case management program could be quite useful in accessing resources to help alleviate this problem.

> Joe is a 16 year old male with light brown hair and blue eyes. He is a tall boy with a large build. He lives with his mother and his half brother Sam. Joe's problems arose in his school performance when his grades began to fall. He also became involved in alcohol and marijuana use. In February, Joe was admitted to the adolescent acute psychiatric unit after making a suicide attempt. Joe had taken three over-the-counter sleeping pills. Joe reportedly speaks to God, and hears voices telling him what to do. Joe has been depressed for some time and according to his therapist seems to suffer from a sense of failure. Joe reports his problem as being a lack of peer relationships and he feels the program will be able to provide this for him.

Perhaps the most important point to remember about these adolescents is that while their disabilities do present problems in their lives, they also possess many strengths. Building on these strengths often minimizes the scope of their problems in other areas of their lives. The job of the case manager, then, is to guide change in need areas when change is possible, to aid functioning in need areas when change is not possible, and to encourage further growth in areas of strength.

UNIT 3

Theory of Intervention: The Family Advocacy Case Management (FACM) Model

Description: This unit provides an explanation of the theory of intervention upon which the Family Advocacy Model is built. The key principle is building upon family strengths, as opposed to the traditional approach of emphasizing problems, is described.

Objectives:

1. List the seven principles of the strengths approach.
2. Understand and describe the importance of each principle.

Activities:

1. As a group, the trainees should discuss differences between the strengths approach and traditional mental health interventions.
2. Each trainee should pick one or two of the principles and discuss their importance in working with adolescents.

UNIT 3

Theory of Intervention: The Family Advocacy Case Management (FACM) Model

Theory of Intervention

The Family Advocacy Model of Case Management proposes that children now thought of as being severely emotionally disturbed be helped with a strengths approach. This model incorporates the following principles:

1. The emotional disability is only one of the youth's characteristics. They are not one and the same.
2. Youth with a disability also have abilities (strengths).
3. Youth with a disability can learn and grow.
4. A youth with a disability is the primary informant on how they experience the disability.
5. A youth with a disability should be part of society, not out of the mainstream.
6. Society should make reasonable accommodations for a youth with a disability.
7. The youth's family is the primary caregiver.

The emotional disability is only one of the youth's characteristics. They are not one and the same. The person who is confined to a wheelchair is not a disabled person but a person who's mobility is impaired. The person who cannot hear auditory speech is not disabled but has a hearing impairment. Likewise the youth who has periodic episodes of auditory hallucinations is not disabled or crazy but is a youth who periodically experiences auditory hallucinations. The fact is except for the most severely disturbed youth, the problem behavior accounts for only a small portion of their lives. The rest of the time they are behaving like all other kids. The point is not that the problems these kids exhibit should be minimized or overlooked. They can cause serious disruptions in their own and others lives. But neither is the problem the youth's sole identity. Jeanne and Jeff are not "crazy kids," they may be kids with an emotional disability.

Youth with a disability also have abilities (strengths). The same misguided labeling process that dumps kids into the "crazy" category, distorting their identity as a whole person, also obscures their talents and strengths. The prejudice which operates here is

that a "crazy person can't possibly be good at anything." The truth is that youngsters with emotional disabilities can play ball, sing, write, imagine, and make friends just like other kids. They may need some special help and support to realize their strengths but they are there for the making. A case in point is Mary. After the case manager took the time to build a positive working relationship with her, Mary was able to play an active role in charting her plans for independent living. Conversations about what was important to her and how she could reach her goals helped her decide to obtain her GED so she could pursue a beautician's training course. Mary later achieved her goals despite a mental health diagnosis which indicated that it was unlikely she could succeed at them.

Youth with a disability can learn and grow. Individuals with physical disabilities continually fight against the prejudice that a handicap in one aspect of their life renders them incapable in all others. On the contrary, a hearing loss does not preclude an acting career. Just as severe nerve damage to a hand should not keep one from being a successful politician, similar prejudices should not be allowed to operate against youth with emotional disabilities. Once labeled it is assumed by some that such a child cannot succeed at school or sports or anything. This prejudice is often perpetuated by the lack of appropriate educational plans which could help to insure the youth's academic success. After nine months in the hospital due to a conduct disorder Randy was placed on trial visit and mainstreamed part time in public school. He was both excited and anxious about returning to his old school. Unfortunately, while the news about Randy's hospital stay preceded him well in advance of his return, no coordination occurred between the school and the mental health services which had worked with Randy. Not surprisingly, Randy's new teacher was also anxious about having this "crazy kid" in class. The school personnel, without sufficient information and staff, were unprepared to help Randy cope with the prejudice he experienced from other kids. His parents were similarly unprepared for Randy's return to school. No plan was set up between them, the school, and Randy's return to school. No plan was set up between them, the school, and Randy's therapists to monitor his progress or even his attendance. Without the support and guidance he needed it was not long before Randy began meeting the expectations set for him and failed both in his behavior and at his school work. Randy's failure was

used as proof that "he can never make it" when in reality he was not given a fair chance. An adolescent with an emotional disability can learn, grow, and change. He may need consistent and long term support to continue to experience success.

A youth with a disability is the primary informant on how they experience the disability. Even well-meaning service providers are too quick to impose their own view of the world upon their client. The professional's investment and emotional attachment to their own particular helping theory leads them to believe they know what's best. This tendency to exclude the client from all but the most prominent steps in the helping process is even more characteristic when working with adolescents and children. Professionals are reticent to ask the client to define their problems in their own words. Jack, who gets around town in a wheelchair, gets angry when someone says "Here, let me help you get across the street." He resents the loss of control and the assumption of total dependence. Likewise the youth who is told what they are experiencing and what they need is not attaining autonomy and independence. In addition the variation between youth with emotional disabilities is so great that the professional who purports to speak for the child is likely to be wrong a significant part of the time.

The fact is that the youth with the emotional disability is the most knowledgeable person for describing what he experiences. Understanding from their viewpoint the anger, fear, confusion, disappointment, and uncertainty which these children experience is the all important first step in helping them. The prescription for doing so is simple: they must be asked. Sam was continually getting into fights at school and complained of loneliness. Through much effort the case manager helped Sam get enrolled in a community recreation program to provide some positive group experiences. Despite Sam's verbal commitment to the contrary, he failed to attend the first session of the program. The case manager's gentle and sincere questions led to Sam's disclosure of being sexually abused as a child. With additional support he attended the recreation program and stopped fighting at school. Mary, who periodically experiences auditory hallucinations, can talk about these events as she experiences them and the protection she needs when they occur. Not all youth have Mary's current ability. However, youth with emotional disabilities can learn what Mary has. They simply require assistance in their learning.

A youth with a disability should be part of society, not out of the mainstream. The ultimate goal of most treatment programs and the professionals who work in them is for the youth with an emotional disability to become a happy and productive member of society. While few would argue with the words which express the goal, the effects of much of the treatment provided to adolescents and children with emotional disabilities is to cut them off from peers and normal community living. Long term hospital stays, no matter how good the treatment provided, place more and more barriers between the youth and their family and community. The best way to learn independent living skills is to practice them. The best way to learn to cope in the real world is to live in it. Fred had been in hospital since age six. Now at age 12 the professionals recognized that he was no longer benefiting from his stay there and in fact was becoming "institutionalized." Yet the prognosis for his return to the community was bleak at best. The case manager met with Fred's mother, the teachers in the school he would be attending, and the staff in the community mental health center where he attended counseling sessions, prior to his return home. These meetings were used to make clear to all parties the expectations for Fred's behavior and to establish support and monitoring systems. The case manager also took Fred to visit his school before his release from the hospital to lessen the shock of his return. Several weeks later this "hopeless" case is doing very well at home in his own community. Some youth with severe emotional disabilities need occasional hospitalization to help them through an emotional crises. But these stays should be as infrequent and short in duration as possible. At least as much effort and money must be put into keeping the youth in a normal environment as goes into their institutional treatment. Family and community are the only places for a young person to learn to be a production member of society.

Society should make reasonable accommodations for a youth with a disability. Entrance ramps which allow access by wheel chairs are now commonplace in America. It is now clearly stated in our society that a physical disability does not justify an individual's exclusion from its services and cultural events. At times providing for accessibility means making special accommodations, such as entrance ramps. An adolescent or child with an emotional disability also may require their community to make responsible accommodations to provide them access to its services. Education is an

indispensable aspect of a child's development. The socialization and knowledge which that experience affords are essential if the child is to experience any semblance of a normal development. Recreation facilities, sports, arts, and entertainment opportunities are all experiences which the youth has the right to expect. It is the responsibility of society to make reasonable accommodations to allow youth with emotional disabilities those experiences. Schools must provide special classes when necessary with trained personnel. Recreation programs should allow for the participation of these special needs youth. They can only learn to behave normally by experiencing normal activities. Sarah expressed an interest in learning to play golf but there was no organized program in her community which would accommodate her special needs. The case manager working through the special education department of a local university located a college student willing to give Sarah golf lessons. She greatly benefited from the positive adult interest shown her and enjoyed her new found recreation opportunity. The next step is to demonstrate to community persons who control access to golf that Sarah can function like others. Those people may also need to learn about Sarah's particular disability, how this may occasionally require a unique response to Sarah, and what that response is.

The youth's family is the primary caregiver. Family members play a critical role in the care of its member with an emotional problem no matter their age. Most children are cared for throughout their youth by their families. Even in cases where substitute care is used it is most often time limited and does not constitute a large proportion of the child's life. The role of family care givers in the habilitation of adolescents and children with emotional disabilities is indispensable. From many aspects, legal, emotionally developmentally, the youth is dependent upon their family. These family care givers must be given the respect and attention commensurate with their role. Professionals must begin treating them as the youth's primary treatment providers. They should be consistently and integrally involved in the youth's treatment from the outset. As much information as possible regarding their child's needs and strengths must be provided to them on an ongoing basis. Any and all professional treatment is doomed to failure without the family's involvement.

UNIT 4

The Goal of the Family Advocacy Case Management Model

Description: This unit describes the goal of the Family Advocacy Model.

Objectives:

1. Know the goal.
2. Understand that specific standards for the successful completion of this goal are relative to the population being served, as well as the size of the worker's case load.

Activity: Discuss how this goal relates to the problem and its relevance to the theory of intervention.

UNIT 4

The Goal of the Family Advocacy Case Management Model

The goal of this program is that adolescents with severe emotional disabilities who become case management clients will continue living in, or will be returned to, their most normal environments. Normal environments are considered to be those which are:

-- Most family like (ideally, the youth's family itself)

-- Involve community activities

-- Include regular school classes and activities that meet the youth's special needs.

In order to make this goal realistic and measurable standards must be specific. For example, for hospitalized clients it may be reasonable to expect that at least 50% of those adolescents will not be rehospitalized after re-entering the community while receiving case management services. Which specific expectations are selected should depend on a variety of factors, including the characteristics of the target population (i.e., status at time case management service is initiated, history of previous hospitalizations, etc.) and size of the case manager's case load.

UNIT 5

Program Objectives

Description: This unit describes the objectives of the Family Advocacy Model. Examples of client outcome, productivity, efficiency, and staff morale objectives for the program are given.

Objective: Explain the purpose and content of client outcome, productivity, efficiency, and staff morale objectives.

Activity: Discuss how these objectives relate to the goal and how meeting these objectives will result in the goal attainment.

UNIT 5

Program Objectives

As stated in the previous unit, the goal of the Family Advocacy Model of case management is to keep adolescents with serious emotional disabilities in their community in normal environments. When working with the adolescent, certain objectives must be met to achieve this goal. The specific standards for measuring the successful completion of each objective are relative to the adolescent population receiving services (i.e. hospitalized clients vs. non hospitalized clients). Therefore, the standards specified in the following description of the program objectives for working with the adolescent should be regarded as demonstrational in purpose, with specific standards reflecting the client population being set each time the program is implemented.

Client Outcomes

Objective 1

Eighty percent of the adolescents will acquire the resources and support from their family and community to meet their needs throughout the period that case management services is provided. Measurement: The adolescent's satisfaction with the resources acquired will be assessed by a "Satisfactory" or above rating on this item in the User Satisfaction Survey which will be administered on a quarterly basis.

Objective 2

Eighty percent of the adolescents will achieve a quality of life with which they are satisfied in the life domains of affection, education, domestic, health, economic, recreation, and socialization throughout the period that case management service is provided.

Measurement: The adolescent's satisfaction with the quality of life achieved with be assessed by a score of 3 or above on each item of the Youth Quality of Life Assessment which will be administered quarterly.

Objective 3

Eighty percent of the adolescents will learn the skills necessary for independent living that are appropriate for their age group throughout the period that case management service is provided.

Measurement: The adolescent's attainment of a satisfactory independent living skill level will be assessed by a "satisfactory" or above rating on this item in the Caregiver User Satisfaction Survey which will be administered on a quarterly basis.

Productivity Measures

Objective 4

The case manager will establish an average minimum of one (1) goal per week with the client family (adolescent or caregiver). This standard is to commence with week number eight after case management services have been established with a family and continues throughout the time the case is in an "active" status.

Measurement: Goal statements submitted to supervisor on a weekly basis and Case Management Outcome Chart.

Staff Morale

Objective 6

The case manager will receive the information, direction, and support from the supervisor and the support and feedback from colleagues which he/she needs to achieve the goal and objectives of the program.

Measurement: The case manager will select at least 90% "yes" responses on the Supervision Rating Form which will be provided by the supervisor following each weekly group supervision session.

The case manager will be provided the opportunity to indicate their satisfaction and/or need for changes in the case management program by listing at least three positive aspects of the program and three things about the program they would like changed. This evaluation opportunity will be provided by the supervisor on a quarterly basis.

UNIT 6

Expectations of Clients and Case Managers

Description: The behaviors expected of the adolescents and the case managers are listed in this unit.

Objectives:

1. List the behaviors the client can expect from a case manager.
2. List the behaviors the case manager can expect from the adolescent.

Activity: Discuss the importance of specifying the behaviors expected of both the worker and the client.

UNIT 6

Expectations of Clients and Case Managers

For a program to be successful, the expectations of every person involved must be specified. These expectations should be behavioral in nature and must be met to reach the objectives of the program and ultimately the goal.

The adolescent client can expect the following behaviors from a case manager working within the Family Advocacy Model.

Expectations of the Case Manager:

1. The case manager will attend training classes in which he/she will learn the resources available in the community and become skilled at:
   - assessing the strengths and needs of the client and his/her family.
   - mutually identifying goals and the strategies necessary to achieve them with the client and his/her family.
   - accessing community resources with the client and his/her family.
   - monitoring the progress of clients in achieving their goals.
   - advocating on behalf of the client to ensure their rights are protected and their needs are being met.
2. The case manager will actively establish a positive relationship (i.e., a relationship which encourages trust, communication, openness, and caring) with the adolescent.
3. The case manager will help the adolescent identify and obtain needed resources by utilizing the skills learned in the training program.
4. The case manager will provide the adolescent with the opportunities (i.e., social situations to interact with peers) and information necessary to learn independent living skills appropriate to the youth's age.
5. The confidentiality of the worker/client relationship will be upheld.
6. Contacts will be arranged in advance and at the adolescent's convenience whenever possible.

In turn, the case manager has the right to expect certain behaviors from his/her clients. While the case manager's expectations of the caregiver are listed in the companion manual, the expected behaviors of the adolescent are as follows.

Expectations of the Adolescent:

1. The adolescent will keep appointments with the case manager whenever possible.

2. The adolescent will not be in an altered state of mind due to substance abuse during contacts.

3. The adolescent will provide the case manager with information concerning his/her interests and needs.

UNIT 7

What the Case Manager Really Does

Description: A general definition of case management is provided. This unit also describes the actual behaviors the case manager performs.

Objectives:

1. List the five basic functions a case manager serves.
2. Be able to describe a typical contact during the relationship building process.
3. Be able to describe a typical contact during the middle phase.
4. Be able to describe the process of termination.

Activities:

1. Brainstorm a number of activities appropriate for the relationship building phase.
2. Role play a middle phase session.
3. Discuss techniques for dealing with an adolescent's response to termination.

UNIT 7

What the Case Manager Really Does

There is not one generally agreed upon definition of case management. Despite its growing popularity and application across the country it is still in the early stages of development as a practice model (Johnson & Rubin, 1983). When discussing the use of case management it is important to acknowledge that many questions remain about the most effective methods for providing it and we must, therefore, remain open to learning and change (Intagliata, 1982). Harrod (1986) suggests that much of the difficulty in specifying the case management concept is due to the "tendency to lump together five or six quite distinct service functions under the label case management" (p. 56).

Despite the absence of total agreement there is considerable similarity among the definitions proffered for case management. "Case management is a developing method of service coordination and accountability in the human services" (Weil & Karls, 1985, p. 1). "Case management is a set of logical steps and a process of interaction within a service network which assure that a client receives needed services in a supportive, effective, efficient, and cost effective manner" (p. 2). Case management can be thought of in terms of its major goal, which is to "assure that long-term patients are enmeshed in a social support system that can be designed in the least restrictive environment" (Cutler, 1981, p. 349).

According to Harrod (1986) a "state-of-the-art definition" of case management includes a) identifying eligible clients, b) assessing needs, c) planning to meet needs, d) brokering, linking, and coordinating services, e) monitoring and follow-up, and f) advocating for needed services. This definition is consistent with the Family Advocacy Model's notion that case management with adolescents is comprised of five basic functions.

assessment - the process of determining strengths, weaknesses and needs.

planning - the identification of specific goals and the selection of activities and services to achieve them.

linking - the referral or transfer of clients to appropriate services.

monitoring - the continuous evaluation of client progress.

advocacy - intervention on behalf of the client to ensure equity (Wasylenki, et al., 1985).

While the above definition provides a solid base for an understanding of case management within the Family Advocacy Model, perhaps this can be made more clear through a description of the actual behaviors a case manager performs.

The case manager's first responsibility is to establish a working relationship with the adolescent. Such a relationship implies mutual respect, trust, and a sense that the case manager really can help. Generally, this is most effectively accomplished by initially meeting with the adolescent in surroundings which make him/her feel at ease. This may be the home, the mall, the park, etc. The actual setting is not as important as the comfort level of the adolescent. This type of setting allows the case manager to actually get to know the child and exhibit a genuine interest in his/her thoughts and ideas. It is this type of respect that will generally break through the barriers and pave the road to an effective working relationship.

During this initial relationship building process, the case manager should be making preliminary assessments. These assessments are made through observations of strengths and needs and the adolescent's expression of interests and problem areas in his/her life.

When the case manager feels that a trusting, comfortable relationship has been established, the middle phase of their work together begins. While the setting may or may not change, the content of the contacts will change considerably. The following description is intended to depict a middle phase session.

Actual Behavior of the Case Manager

It is expected that the case manager will have set the date and time for the session with both the adolescent's and the parent's approval. The case manager will arrive on time, or call to say that there has been an unavoidable delay. Upon arrival the case manager will announce his/her presence and wait for permission to enter. Common courtesies should be extended to all family members present.

As in any informal social contact, the case manager should inquire as to the family member's health, etc. It is expected that the case manager will come with a prepared agenda which may or may not have been discussed during previous contacts. The adolescent should be made aware of what the case manager hopes to accomplish. The case manager will check with the adolescent to learn if he/she has additional or more

pressing items for discussion.

Each individual present who has a legitimate role to play in the session will be given the opportunity to participate. This may require assertive behavior on the case manager's part such as asking the person a direct question. The case manager is expected to take appropriate action if any one person monopolizes the conversation. The conversation should be kept on focus through a variety of techniques.

In the event that distractions occur which interfere with a productive discussion the case manager will request that it be removed (e.g., tv or radio too loud). It is also appropriate to request that the meeting be moved to another room if necessary.

During the middle phase of work the contacts with adolescents will be primarily devoted to identification of goals and strategies to achieve them. Goals can be initiated by the adolescent, parent, or case manager. Regardless of who initiates the goal the process must be a mutual one. The goal and strategies will eventually be recorded in written form and the adolescent's signature affixed.

While written goals are the tangible outcomes of the program, an important aspect of case management is relationships. Therefore, the session should provide many opportunities for expression of humor, caring, and emotions appropriate to the time and people present.

The session should be kept to a reasonable length so that it does not become an inconvenience for anyone involved. One hour is a reasonable standard. However, the case manager must be sensitive to this or other factors which may cause discomfort during the meeting. In the closing phase of the session the case manager is expected to thank those involved for their time and assistance. The next meeting date should be established at that point.

While the above session is one in which both the adolescent and the caregivers are present, it effectively describes the particular process. When meeting with the adolescent alone, however, the case manager should remain quite informal and relate to the youth on his/her level.

The final phase in working with any client is that of termination. When the case manager feels that the client has obtained the needed resources from the community and that his/her services are no longer needed, this phase of the case management process begins.

Termination should be gradual. Meetings may become less frequent with phone calls taking their place. Eventually, the case manager may wish to tell the client that he/she can call if a problem arises. This will give the client a sort of trial period when he/she is on his/her own, but still feels the support of the case manager. When the client is able to function in the community with the support of the acquired resources, it is time to discontinue case management services.

The case manager must remember that an important relationship in the adolescent's life is ending. The adolescent may express a variety of emotions and behaviors. These an include denial; regression, in an attempt to hold on to the case manager; anger; or withdrawal. Whatever the reaction, the case manager should continually help the adolescent define his/her emotions and learn to deal with them appropriately, throughout the termination phase.

UNIT 8

Assessment Through the Life Domains of Family Functioning

Description: This unit describes the seven functions a family performs and how these can be used to assess strengths and needs areas.

Objectives:

1. List the seven family functions.
2. Understand what behaviors are covered by each of the family functions.

Activities:

1. Provide the group with case examples which can be used to assess strengths and needs in the seven life domains.
2. Each member of the group should pick a life domain and discuss how impaired functioning in this area could present problems in an adolescent's life.

UNIT 8

Assessment Through the Life Domains of Family Functioning

This case management model uses the seven family functions identified by Turnbull (1984) as a framework for the categorization of strengths and need areas in the adolescent's life. The family can be thought of as a system whose primary job is to meet the needs of its members. Family functions are those activities the family must perform to meet those needs. The domains in which these functions occur are: affection, education, domestic, health, economic, recreation, and socialization.

The family advocate's awareness of the seven family functions can be useful in the three ways described below. Examples are given to illustrate those uses.

- An assessment of how the youth is doing in each of the seven family functions can provide an inventory of the youth's strengths which can be used to build the individual's confidence and self-esteem. For example, a case manager may express the following thoughts to an adolescent:

> Mary, I know that you're having a difficult time in school (*educational function*) right now but I think you've done a great job lately in doing your chores at home (*domestic function*) and your mom is really happy about it. Also, your volleyball coach thinks you can be a good player (*recreation and socialization functions*). So don't get discouraged and go off on your teachers. Lets talk about ways to make things better at school.

- Reference to family functions can be used to interpret a youth to other service providers. For example, the following could be expressed by a case manager speaking to another professional on behalf of a young client.

> You know, I think in your role as the state protective service worker you've had to focus upon Andy's problems but he also has lots of strengths. Did you know that Andy enrolled in the summer recreation program (*recreation function*) and is planning to help his dad cut lawns this summer to earn spending money? (*domestic and economic functions*)

- The family functions can also help the case manager assess the youth's needs in order to get the helping process under way. For example, during group supervision reference to other family functions by the supervisor can avoid emphasizing the negatives.

> We've spent the last few minutes expressing concerns about Sarah's school problems and that is an important concern. However, let's look at how she's doing in some other areas. Didn't you tell us last week that Sarah is beginning to get along better with her father and not fighting as much with her younger sister? (*socialization and domestic functions*) That shows some willingness to change and real progress on her part. Be sure to praise her for those successes. Now let's brainstorm ways we can help her at school.

Each of the seven life domains of family functioning are defined below.

Affection

Affection functions of the family are the nurturing and love experienced by the members of the family. The companionship, level of intimacy and expression of emotions all fall into this category. Do members of the family feel loved? Where do members of the family receive emotional support? Are persons respected? Do parents have authority in the family? Are feelings expressed openly in the family? Do people feel needed and worthwhile? These are all questions that the case manager can assess with the family to identify their perspective on the family function of affection. Both the strength and needs are to be identified from adolescent's perspective which may be different from other members of the family. These differences should be identified on the perspective tool.

Education

The education function includes assignment of tasks and responsibilities in the home as well as the family's perspective on formal education. Are job assignments fair? Do members keep up with their tasks and responsibilities? Do parents communicate with school personnel? Is the youth encouraged to attend school? Is school work important? Does the family provide time and direction for education in school, social situations, and spirituality?

Domestic

The domestic functions of the family include the physical and transportation needs of the family. Does everyone have adequate clothing? Do they feel safe and comfortable in their home? Is the home adequate? Is adequate transportation available?

Health

This area includes adequate health care, and nutrition. Does the family have adequate food? Does the family have adequate medical and dental care? If a member of the family has a medical regimen to follow is it adhered to?

Economic

The economic functions of the family include the family's financial status, its ability to meet debts and provisions for insurance. In addition this function includes the family's teaching the children about handling money. Some questions to assess this

family function include: Does the family have adequate health insurance or medical coverage? Do they adequately meet their debts? Do the parents work? Do they have adequate money to meet their needs? Are children taught about handling money?

Recreation

The recreation functions of the family include the family's participation in recreational activities and the family's ability to be involved in fun and relaxing time. Questions to focus the assessment can include: Do they participate in recreational activities? What kind of activities do they enjoy? Do they have enough money to be involved in fun things?

Socialization

The socialization functions of the family include the family's interpersonal relationships and the social activities that they are involved in. Which activities are they involved in? What kinds of activities would they like to be involved in? Do they have close friends? These are a few questions that the case manager can ask to assess the family's functioning in this area.

UNIT 9

The Goal Setting Process

Description: This unit describes goal setting with an adolescent.

Objectives:

1. Understand that goal setting is a mutual process.
2. Know that goals should reflect resource acquisition.
3. List the seven necessary steps in the goal setting procedure with adolescents.
4. Identify and describe the five standards which must be met in the statement of goals.
5. Identify ways to work with adolescents in setting goals.

Activities:

1. Each group member should identify two areas in his or her own life in which a goal could be set that they had not previously thought of.
2. Brainstorm a number of resources available to aid functioning in each of the life domains.
3. Using case examples, have each group member write down a goal. Go around the group and evaluate the goal statements using the goal setting standards. Rewrite the goals that do not meet the standards.
4. Role play setting a goal with an adolescent. The instructor should set up the situation and give a brief description of the youth.

UNIT 9

The Goal Setting Process

Goal setting is the process by which the youth, the family, and the case manager mutually decide upon objectives to work toward which, when met, will develop the youth's and family's strengths and meet the basic needs defined during the assessment. The process of establishing goals with the adolescent is a natural progression that results from a positive, trusting relationship.

Each goal setting process will be different but most of them will follow a similar sequence. Out of a trusting relationship will come open, honest discussions about the adolescent's interests, talents, and problems. From these discussions the case manager and the adolescent can begin to formulate plans which will help expand those interests, encourage growth in areas of strength, and change or lessen problem areas.

It is important to remember that goal setting with the adolescent is a mutual process. This does not mean that the case manager can sit back and wait for the adolescent to tell him/her what goals should be worked on. Rather, the case manager should listen to the youth, interpret what the youth needs and wants, clarify that the interpretation is correct and then actively help the youth operationalize the goal. The case manager is teaching the adolescent important survival skills; specifically those of deciding what is needed in his/her life, prioritizing those needs, and then formulating a step by step plan of how to obtain what is needed or desired. Most of these youth have had no prior experience with this sort of planning because a myth exists that emotionally disturbed children are not capable of even knowing what they need, let alone performing this process. While this idea is generally unfounded, the adolescent's lack of experience here may mean that the case manager will have to take an aggressive role in the goal setting process.

> Randy told his case manager that he had been offered a job that he was excited about, but that he would not be able to accept it because he had no means of transportation.
>
> Randy was ready to forget the job offer and certainly did not see any sort of goal to work toward here. It was the job of the case manager to suggest to Randy that perhaps he could car pool with a co-worker, take the bus, or even obtain a driver's license and use the family car. After discussing the situation with his parents, it was mutually decided that Randy would get his driver's license and would be allowed to use the car to get to work.

The point here is that the case manager did not wait for Randy to say "I would like to

get my driver's license," but instead offered solutions for a problem and then helped select the best answer.

It is also important to remember that the case manager's major responsibility is resource acquisition. In the above example, the case manager could have offered to drive Randy to work every day. This, however, would only increase Randy's dependence. The ultimate goal of the case manager is to help the adolescent to one day become a productive, independent member of the community. This will only be possible if the adolescent is connected with the resources to provide support in every area of his/her life where needs or possible growth exists. Examples of such resources include:

educational	-	the public library
		a tutor
		GED classes
		local junior college class
health related	-	Planned Parenthood
		Alcoholics Anonymous
		Hospice
		Outpatient Psychological Services
recreational	-	YMCA
		Youth Symphony
		Parks and Recreation

Resources exist to help in every life domain and it is the responsibility of the case manager to help access as many as are needed for the youth to attain a quality of life with which he/she is satisfied and to remain in the community. Goal setting, then, should focus on this type of resource acquisition.

Once a goal has been set, the case manager and adolescent should specify exactly what actions must be taken and who is to perform what behaviors. This is called an action plan and will be discussed in further detail in Unit 10. For now, an example of the information recorded on a goal planning sheet may prove useful in this explanation of the goal setting procedure. (A sample Goal Sheet is included in the Appendix.)

Goal: To Obtain a Driver's License

	Steps	Responsibility
1.	to obtain a learner's permit	case manager & Randy
2.	to set times with mom and dad to practice driving	Randy
3.	to pick up a driving manual	case manager & Randy
4.	to study the driving manual	Randy
5.	to set up an appointment to take the test	Randy
6.	to take the test	Randy

These goal planning sheets are merely a guide and may be revised or even discarded if other steps become necessary or if the adolescent changes his/her mind on the plan he/she wishes to follow.

The following, then, is a review of the process necessary in the goal setting procedure.

1. Discuss strengths and needs with the adolescent.
2. Interpret goals from events in the adolescent's life and from what he/she says.
3. Clarify with the adolescent that the interpretation is correct.
4. Prioritize goals if more than one exists.
5. Brainstorm ways to reach the goal with the adolescent.
6. Choose the best plan.
7. Formulate a step by step plan, specifying exactly what is to be done and by whom.

The experience a case manager had with Joe provides an excellent example of this goal setting procedure.

> Early on in our work together, Joe was enthusiastic and eager to work toward his goals. He defined several goals: enrolling in a GED program and earning a diploma; getting a part-time job; refraining from further alcohol and drug use; and improving on his relationships with family members. One of his priorities was to enroll in a GED program and complete the tests necessary to get his diploma.
>
> Together we broke down the steps to accomplish the goal. The first was to review the available programs and alternatives in the area. We did this by my finding out where the adult GED program was available and setting up a meeting to meet with the personnel at the Education Learning Center. Once he was enrolled we agreed on his attendance schedule and the academic areas on which he wanted to focus.

> Before he could take the tests he had to meet a number of criteria. He had to have written permission from his last school to take the test; he had to have a valid ID; he had to have $25.00 to pay to take the test; and he had to sign up for when he wanted to take it. Over the next few weeks we set out to accomplish each of these steps. At first they seemed to be overwhelming to Joe but as we broke them down they were more manageable. We contacted his last high school and the principal agreed to give him the letter. We secured a valid ID which also meant getting a birth certificate and made application with JEPTA so they would pay for his taking the test. Through much support and encouragement Joe set a date to take the test (D. Hummel, 1987).

While this is the usual process it is important to mention that occasionally smaller goals will be attained without any prior planning.

> The case manager picked Mark up at his house. They were having trouble deciding what to do and Mark mentioned he had to give a speech at school the next day and he wasn't sure how to write it. The case manager took Mark to the public library where he had never been before. Together they researched and worked on his speech.

In this instance the case manager has accessed a resource (the library) and accomplished a goal (she taught Mark the necessary steps in writing a speech) without actually planning to do either.

In the actual writing of goals, the following are standards which must be met:

1. *Goals must be stated in positive terms.*

State what it is that the youth and/or family is expected to do, rather than defining what they are expected to stop doing. For example, "Joe will play golf with Fred," rather than, "Joe will stop hanging out at the mall."

2. *Goals must be youth and/or family oriented.*

What is the youth and/or family going to achieve? For example, "Sue will participate in the Youth Symphony," rather than, "The case manager will arrange for Sue to try out for the Youth Symphony."

3. *Goals must be realistic and achievable.*

Incremental steps toward each goal must be clearly stated so that progress is observable to the youth and/or the family and the case manager. For example, "Gerald will attend weight lifting classes on Tuesday evening at the YMCA," rather than, "Gerald will increase his social interactions."

4. *Goals must be measurable and observable.*

Keep the goal statements clear of adjectives and adverbs and set a single measurable standard. For example, "Rita will complete the GED program," rather than, "Rita will successfully complete . . ."

5. *Goals must focus on resource acquisition, not behavior change or psychological change goals.*

For example, "Jim will join Golden Gloves," rather than "Jim will stop fighting."

Working with adolescents is not always easy and the following might be helpful to the case manager in setting goals and objectives with them:

1. Get them to identify what they want to see different in their life.

2. Reframe problems or weaknesses to identify strengths and goals.

3. Set up reinforcers that will insure that the adolescent will work on the goal. Since all you have is your time and your relationship with the adolescent, use it to reinforce goal achievement.

4. In defining goals use the adolescents' behavior to help identify what it is they want, e.g., if the behavior is not getting to appointments on time, define the goal as attending the GED class each day.

5. Remember that adolescents, more so than adults, change their mind a lot. Therefore do not get frustrated if they change the goal they want to work on after you think it has been set. Be flexible and listen for the theme of the goals as they change it, to help identify what it is that they want to have different in their lives.

6. Be careful to not set goals that are "cure" goals. For example, "not be schizophrenic any more." Rather, use this statement to get them to identify what about their disability they want different.

7. Listen and observe carefully as many times a goal will be identified in informal conversations.

8. Be patient and do not push for goals to be defined until you have established a trusting, positive relationship with the adolescent. For some young people this may take some time and if you push them the goals will not be genuine nor will they be willing to follow through on them.

9. When the child identifies a global or long term goal break it down into the steps necessary to achieve the goal and set goals that meet the standards cited earlier.

10. As much as possible include the parents of the adolescent from the beginning in defining the goals and the steps toward completion.

UNIT 10

Action Plans and Monitoring

Description: This unit describes the next three steps in the case management model: setting an agenda for work, monitoring progress, and linking with resources.

Objectives:

1. Break down short term goals into discrete tasks to be accomplished by the case manager and the adolescent.

2. List the eight questions that indicate that monitoring is taking place.

Activities:

1. Agenda setting - The instructor is to select goals and write them out on a flip chart. Have each trainee write down all the steps that would be necessary to accomplish the goal and who would be responsible for its completion. The instructor can utilize the goal setting sheet that is a part of the assessment package. After each person has had time to write out the steps, the group can discuss their answers.

2. Monitoring questions - The instructor should have the eight monitoring questions on 3x5 cards to be given to each trainee. After discussion of the importance of each of the questions the instructor can ask them to use the cards after each meeting with a youth or their family.

UNIT 10

Action Plans and Monitoring

This section describes the next steps in the case management process: setting an agenda for work; and monitoring progress and linking with resources.

Creating an Action Plan

Setting out the steps to accomplish an agreed upon goal is a critical element in building social competency as well as in determining the successful outcome of the work the case manager and the adolescent will do together. There are two dimensions of clarity that are important in the establishment of the agenda: clarity of task and clarity of responsibility. The agenda is the tool that the case manager uses to break down the short term goals into small incremental steps which describe who is to do what, and when the behavior should take place. The agenda is to be set by the adolescent and the case manager in a collaborative effort. In all goal setting agendas the parents should be kept informed of the agenda and involved as needed for its implementation. Decisions are to be based on the youth's needs and as much as possible should be actions they can take independently. Therefore the case manager should assume the role of consultant when ever possible, offering the youth options, consequences and suggestions.

The best way to start is to provide as much assistance as is necessary to insure achievement and as the youth experiences successes, to withdraw the assistance in each incremental step. In most cases, the steps should be planned and written out in advance of taking the first step to insure that the youth is aware that each step leads to the final goal. Not only will they be learning how to accomplish a specific goal but how to set goals and accomplish tasks that may seem initially too difficult or frightening to attempt.

An example of an action plan follows:

LIFE DOMAIN: Domestic

GOAL: Jim will obtain clothes sufficient to feel comfortable at school.

PLAN:

1. Locate sources of clothing. Case manager responsible.

2. Go to Let's Help and see what is available. Adolescent and case manager responsible.

3. Make appointment for school clothing bank. Case manager responsible.

4. Inform mother of possible options. Case manager.

5. Talk with adolescent and his brother about their feelings about getting donated clothes. Case manager and adolescent responsible.

6. Take adolescent, his brother and mother to get clothes. Case manager and family responsible.

Monitoring Progress toward Goal Attainment
and Making Revisions When Progress is Not Made

In the early stages of agenda development the case manager is responsible for monitoring the degree to which activities documented on the agenda are being completed. This can usually be done in the regular case management meeting and complimented by checking with the resource as needed. Once a supportive relationship is built with the collateral, contact can be less frequent and can often be done by phone.

Monitoring is not the responsibility of the case manager alone. The youth's family can and should be actively monitoring some of the goals as should the supervision group. Reviewing cases with the supervisor on a regular basis serves the same purpose for the case manager as it does for the youth. It conveys that the team is interested in, and supportive of, the work being done.

When progress through the steps stops, it is a signal to the case manager that something is wrong with the step that is not being achieved. Discussion with the youth or resource persons will usually result in a clearer understanding of the barrier to attainment. The step should be changed to overcome the barrier and new alternatives should be generated. Many times the change that is needed is to increase the support of the youth by others. If there is a breakdown in a number of goals the case manager may want to hold a resource meeting to discuss what needs to be done to shore up the necessary network of support for the youth. This meeting should include the youth, (if he/she is willing), their parents, the case manager, and the resource people involved with the youth. Everyone who is to attend should know the purpose of the meeting and there should be no surprises for any of the participants as to the agenda. Again the goal is to generate alternatives that will insure the accomplishment of the goals and understand the barriers to goal attainment.

Monitoring of activity is an important part of case management and, unfortunately, one that is often forgotten. The case manager needs to be sure that monitoring takes place. If the following questions can be answered by the case manager, monitoring is taking place.

MONITORING QUESTIONS

1. When is your next meeting with the adolescent?
2. Which goals and steps will be discussed?
3. What tasks are you to have done before the next meeting?
4. What tasks is the adolescent to have done before the next meeting?
5. Is the adolescent still using resources as planned?
6. How do resource people think the service delivery is working?
7. How do the youth's parents think the plan is working?
8. If there are any problems in the linking between the youth and the resources, how are they being resolved?

After achievement of the first set of goals is attained the case manager with the youth select the next set of goals and follow the same steps toward achievement. The case manager needs to continue to monitor the status of the youth/resource linkages that have already been established. Also the ongoing performance should be reviewed with the other members of the team periodically in order to direct immediate attention to any problems or barriers that might appear.

UNIT 11

Intervention Strategies

Description: This unit describes the two major categories of case management interventions--activities and resource acquisition.

Objectives:

1. Identify the four stages of the use of activities with adolescents.
2. Describe the three phases of acquiring environmental resources.

Activities:

1. Each trainee is to do their own strength assessment. They are to write down activities and hobbies they enjoy doing. The instructor is to facilitate the discovery of areas of interest for the trainees by asking questions that will cover all of the life domains.

2. Resource Acquisition. The instructor is to select a situation and play the devil's advocate with the group. The instructor will play a new case manager and the trainees will play the supervisor. The trainees are to take turns trying to come up with a resource that satisfies the need identified. The instructor should incorporate the following barriers into the role play: not having enough money; the youth's behavior is inappropriate; there is a problem with logistics; the adolescent's parents are not supportive; the resource has limits and expectations; the child is not capable; there is not enough time; the adolescent won't do it without the case manager.

UNIT 11

Intervention Strategies

Case manager interventions can be grouped into two categories. The first category involves the use of activities that the case manager can engage in with the adolescent to set goals as well as to accomplish some of the goals. This category emphasizes the relationship building functions of the case manager. The second category involves tasks designed to acquire environmental resources with and on behalf of the adolescent and their family. This category emphasizes the brokerage and advocacy functions of the case manager.

The Use of Activities

Most adolescents with emotional problems have been in relationships with helpers that has meant their talking about their problems and learning how to handle their feelings. In the role of case manager we want to establish a different kind of relationship that is based on the youth's strengths and their abilities to handle things in their lives. We want to establish a level of trust with them that can be used to accomplish goals that are set in a mutual relationship. One of the best ways to establish such a relationship is through the use of activities rather than a talking type of therapy. The activity can become the vehicle for the nurturance of the relationship and reinforces that the youth is a capable and valued person. It also offers the adolescent and the case manager the opportunity to talk about things that are part of a natural process of what is going on at the time. For example when you are walking down the mall together and the adolescent notices some one they like you can use it as an opportunity to talk about ways to get to meet people.

The case manager can do something with the youth, either something they like to do or something the case manager likes to do. Just hanging out together can be very positive in demonstrating to the youth that the goal is getting to know each other and for them to find out that the case manager is not out to "fix" them. Going out for a coke, playing a board game, playing computer games, going for a ride, or taking them on an errand you need to get done, are all possibilities. The use of some non competitive sports activities might also be an avenue for the youth and case manager to spend time together. Doing home work or attending some activity that the youth enjoys can offer

the opportunity for the case manager and youth to begin to build a positive relationship. During this stage there are no expectations other than to get to know each other and the case manager is cautioned not to move to fast or try to get the youth to talk or identify goals. The case manager's focus during this phase needs to be on allowing and supporting distance, inviting trust gently, facilitating exploration, and providing structure around their role in the relationship.

As the relationship develops the use of activities changes to become more focused on the goals of the youth. Here the activity will have a more specific purpose and relate to what the case manager and the adolescent have agreed upon. These will include a range of things depending on the youth and should be activities in which they want to participate. These might include things like learning how to sew, setting up a weight reduction program, learning how to play a sport like racquetball or swimming, or participating in a shopping trip. The activities will again offer the opportunity for the youth to raise areas of concerns and can give the case manager realistic situations to talk about with the youth. During this phase the case manager will provide activities for mastery, clarify responsibility, clarify feelings both positive and negative, and be supportive to reassess accomplishments when necessary and to reward accomplishments when goals are reached.

Once a fairly strong relationship has been established with the adolescent the case manager can use the relationship to have the youth take more responsibility to establish the activities. This also will be a time for the case manager to have the youth do more things outside of the relationship and then to use the time they have together to talk about how it went and what they want to do next. The focus in this phase is for the case manager to facilitate opportunities for the youth to act in other groups and the community, and to facilitate the evaluation of the process with the youth.

The last phase is for the case manager to transfer the involvement in the activity to someone in the community. This will offer the youth an opportunity to be involved with people in the community in non-helping roles and make for more normal ongoing relationships. The focus in this phase for the case manager is to let go, facilitate a positive transition to another person, evaluate with the youth the accomplishments, and terminate.

Acquiring Resources

One of the primary objectives of this case management model is to help adolescents and their families acquire the necessary resources to meet their needs. This resource acquisition takes a dramatically different perspective. Traditional interventions suggest that professionals know what is best or that people with emotional problems have limited responsibility for their behavior or lives. The model of case management does not concern itself with group differences but assumes that all people are different and that in our pluralistic society, differences are a source of strength. Therefore all people have unmet needs and are responsible for their own lives and behavior. Every person has problems, strengths, limits, goals and aspirations and the case manager's job is to help each individual and family attain their goals.

The general process through which a resource is acquired is based on the model suggested by Davidson and Rapp (1976). The model is broken down into three phases: 1) assessment; 2) strategy selection; and 3) implementation. Although the model is described sequentially, in operation there is considerable interaction between steps so that the order depends on the situation.

The first phase is assessment. After the case manager has fully assessed the youth's and family's needs through a strengths assessment, he/she must assess the resources available to meet the goal. Too often this step is ignored because the case manager only uses resources that may be immediately obvious. However, the immediately obvious resources may not include all the possibilities, nor are they automatically the best. The case manger is cautioned to not only access traditional resources but to find as many alternatives as possible. An example is a 12 year old pre-adolescent who enjoyed playing golf and had no adult male role models to spend time with. The case manager checked into the resources through the athletic department of a local university and located a man who enjoyed playing golf and was interested in spending some time on a regular basis with an adolescent.

In looking for resources for adolescents it is best for the case manager to look for people or organizations in the child's environment. Many times within the youth's ecological frame work there are people who are natural resources for the adolescent. A neighbor, a relative, or a person in the child's school may all be potential resources for the youth. Asking the adolescent who they would go to in their neighborhood if they

were hurt and their parents weren't home or who they would like to get to know, can begin to give the case manager a sense of who the youth sees as potential resources. Spending time with the youth to find out what his daily pattern is and who he comes in contact with is another way to assess his/her world. This phase of assessment includes such tactics as brainstorming, investigative reporting, and legal research. The case manager will pick up a number of potential resources from listening carefully to who the youth talks about when they are spending time together.

For those resources that are of a more formal nature the case manager will have to identify who is in control of the resource and who to access within the organization. For those resources that are not available or obvious, the case manager can look at possible individuals or organizations in the general resource area as a starting point. It is necessary to push the traditional limits and be creative in finding resources that could meet the goals. Some examples are:

* Church groups
* School personnel other than teachers
* Athletic groups
* Sororities and fraternities
* Associations of older citizens

No matter which avenue the case manager takes, the process calls for selecting the resource that will satisfy the unmet need and is most likely available.

The next step of the assessment is for the case manager to assess those factors to which the resource individual or organization would be most responsive and would lead to the provision of the needed resources. The case manager will have to assess the relationship between the youth and resource, the level of influence and control the resource has, and other issues that will be useful in determining if the resource will best meet the needs of the youth. This step has many implications for the effectiveness of the strategy. Adequate time and effort should be devoted to developing an accurate and complete picture of alternative targets.

The second phase of acquiring resources is to select strategies that will generate or stimulate a particular resource. These strategies range on a continuum from a positive end--gaining the good favor of the person or agency in control of the resource

--to a negative end--where the case manager could decide to take direct aversive action against the critical individual or agency. The skills necessary for accessing the resource range from a positive "salesmanship" approach to aversive approaches. The case manager will have to select a strategy that could be positive, negative or somewhere in between. The in between strategies are more like a consultation, in which the case manager shares information to the critical individual or agency about the area of unmet needs. For example when a 13 year old was being mainstreamed back into a regular school setting the case manager spent time with the teacher talking about the youth and offering consultation of ways to respond to the youth. The case manager spent time in the class room at first as well as talking to the teacher on his breaks.

There is another set of strategies that the case manager can employ to get the resources, by bringing about a change that ranges from the individual level to the societal level. These strategies can take longer, but in some situations it may be necessary to get the needed resources for the adolescent and their family.

The actual combinations of strategies that result in accessing a certain resource are endless and depend on the situation, the people involved, the resource in question, and the person controlling the resource.

In selecting the strategy to use, the critical element of the model is to select a strategy that will produce the needed resource. This will be determined in large part by the youth and their family. At the heart of this model is the value that people have the right to assess and control their environmental resources. It is critical then that the adolescent and their family be involved in the selection of the necessary resource as well as in the selection of a strategy for its acquisition. The case manager must be conscious of the consequences of the strategy chosen and chose strategies that offer the highest possibility of attaining the necessary resource at the same time minimizing any potential negative consequences for the youth, their family, the case manager, or the resource.

The final phase of acquiring resources is to implement the strategy. The decision of "who will do what?" is critical at this step. In particular the case manager with the youth and their family have to decide if the case manager will act for them, with them or have them initiate the effort. Whenever possible the adolescent and their family should be given as much responsibility as possible. Therefore, the adolescent

and their family should be the primary acquirer of resources. The case manager can discuss ways to access the resource, do role plays, provide support, and teach, to enable the young person and their family to assume more responsibility than would be otherwise possible.

A strategy that fails to produce the needed resource means that either new sources of resources need to be considered or that new strategies need to be developed. The learning that occurs during an unsuccessful effort should be used to formulate a revised plan. An example of this involved a 16 year old male. One of the presenting problems was his aggressive behavior and the number of fights he was getting into.

> Jim was very interested in sports and had mentioned that he was he enjoyed playing with the punching bag a school. As I was interested in helping him get involved in an activity, when I learned of the Golden Gloves I thought Jim would be interested. I called one of the board members of the Golden Gloves to get the specifics. I learned that they were interested in working with underprivileged children and that they would be willing to pay Jim's fees to the local and national boxing associations. They would also cover insurance for Jim. I found this almost too good to be true since Jim's parents did not have insurance. When I finally mentioned this opportunity to Jim he was really enthusiastic. I made an appointment to take him to the gym so he could get a feel for the place and meet some of the members.
>
> Jim really seemed excited down at the gym, yet I could tell that he was a bit uneasy with all these new males around. I was worried about how Jim would get to the gym twice a week, but as it turned out one of the members lived in Jim's neighborhood and was willing to drive him to the gym. I left it up to Jim to arrange transportation with this man. Jim was to begin at the club the next week.
>
> When I talked to Jim's mother the following week she said that Jim had decided he didn't want to participate and was afraid to tell me because he thought I'd be mad. When I talked to Jim he said he just wasn't interested, but was afraid to hurt my feelings.
>
> I later learned that the man who was to provide him transportation was someone who had gotten Jim in trouble before and Jim didn't like him. I also realized through discussion in group supervision and with Jim that he didn't want to take part because he was suspicious that every man was homosexual. Jim had been molested by his older brother and had only begun to work through some of his feelings about it. This gave us an opportunity to talk about these issues and alter the goals to help him overcome his fears in a less threatening way (S. Sexton, 1987).

If the goal attainment is successful the case manager, with the adolescent and their family, is ready to move to a new task related to the same goal or to a new goal. The process to follow is the same as stated earlier and can build on the accomplishments of the goals achieved.

UNIT 12

The Importance of Relationship

Description: This unit describes what is meant by an "effective working relationship," and its importance in dealing with adolescents.

Objectives:

1. Describe the characteristics of an effective working relationship.
2. Understand why the relationship is an essential element in case management with adolescents.

Activity: Each member of the group should discuss the behaviors in his or her own relationships that signal the development of a trusting, caring relationship.

UNIT 12

The Importance of Relationship

While much has been said about forming an "effective working relationship," exactly what this is, and its importance, bears further discussion. This type of relationship is one which fosters a sense of trust, genuine caring, and respect.

For anyone, but even more so an adolescent with an emotional disability, self-disclosure may be difficult. Many of these children have been in and out of therapy and had many contacts with those in the helping profession. From these experiences they have learned the "right" things to say. For example, when asked upon a first meeting what goals they would like to work on, adolescents have been known to give such responses as "learning to control my anger," or "working on developing interpersonal relationships." While these may certainly be worthwhile goals, they are hardly the words of a twelve or thirteen year old. These responses have been learned through positive reinforcement throughout their associations with helping professionals and rarely reflect the adolescent's true feelings.

To begin to open up, the adolescent must trust the case manager and feel free to express him/herself without the fear of rejection. Throughout the relationship building process, the case manager must prove to the adolescent that he/she cares what the adolescent feels he/she needs. This is done as it is in any relationship, through listening and showing respect for the adolescent's ideas. At first this may mean talks about the day's events, what their favorite classes are, favorite tv shows, etc. As the relationship progresses, it means allowing the adolescent to explore his/her options.

> Teresa is a thirteen year old client. She expressed to the case manager that she wanted to get a job. Rather than telling her she was too young, the case manager took Teresa to different employment offices and the Topeka Youth Project, which helps adolescents in the area obtain employment. While Teresa was told that she was not old enough, she was put in touch with resources she could use in the future. The case manager also gained further trust by supporting her and allowing her to explore the possibilities in the area in which she had expressed interest. The case manager was then able to discuss the options of baby-sitting, or a volunteer position.

The most important point to remember is that such a relationship takes time. Building trust is not easy, but it is an important part of the case management process. Perhaps the most important part, because without this type of relationship, generating genuine goals with the adolescent may not be possible. From a trusting relationship comes the ability to work together on important issues, the ability to fail, and the ability to try again.

UNIT 13

Affective Involvement

Description: This unit describes techniques for dealing with adolescent responses and the emotions a case manager may experience.

Objectives:

1. Identify the typical affective responses of adolescents and appropriate ways of handling them.

2. Identify ways for case managers to deal with their own affective responses.

Activities:

1. Role play a case manager dealing with each of the affective responses listed for adolescents.

2. Discuss as a group the importance of honesty, the use of peers, and self assessment in dealing with one's own emotions.

UNIT 13

Affective Involvement

Adolescents with emotional problems are typical adolescents in every way but have some unique ways that they deal with their emotions. In trying to understand these young people most theories focus on the characteristics that make these adolescents different from the rest of the adolescent population. For the case manager to be effective in working with adolescents they will have to take a different approach and focus on the characteristics that make these adolescents the same. The case manager will quickly find out that the behaviors these young people exhibit and the way they express themselves is not all that different from any adolescent. While these adolescents have some special problems they are more like other youth their age than they are different.

With these thoughts in mind, the following are some typical affective responses that the case manager needs to be ready to handle in working with youth. We will also suggest some strategies for the case manager to utilize in dealing with the adolescent.

AFFECTIVE RESPONSE	CM STRATEGY
Aggressive--threaten to hurt someone else.	Calm the youth down. Get in between the two and take control. Set limits on behavior tolerated.
Cussing and provocative. Calling you names.	Ignore the behavior. Refuse to listen. Walk away. Change your body position to ignore the youth. Set limits on the behavior.
Expression of sexual fantasy.	Ask them where they came up with it. Check it out with reality and point out that what they are saying is different from what they are doing. Listen for the meaning and ask about the theme rather than talking about the fantasy.
Sexual provocative behavior, i.e. young male with an erection, young female flirting.	Ignore and don't give any credence. Give them information about sexuality. Set limits on the relationship.
Visual hallucination.	Reassure them that it is a visual hallucination and is not real. Change the subject.
Auditory hallucination.	Reassure them that it is not real. Structure their time.
Talking like an animal.	Ignore and do something else.

AFFECTIVE RESPONSE	CM STRATEGY
Talking about delusions, i.e. continual talk about feces, blood, or guts.	Refocus their attention. Refuse to listen to it.
Literally climbing the wall.	Tell them to stop and set limits.
Withdrawal, i.e., refusing to say anything.	Don't push. Be patient. Just hang out with the youth.
Not volunteering information.	Ask questions and take the initiative.
Bullshit.	Confront. Point out contradictions.
"I don't care" attitude.	Put it back on them and wait.
Manipulative behaviors.	Clarify by questioning. Confront. Set up meeting to clarify in front of the parties involved.
Blaming the case manager.	Put responsibility back on them for their behavior, thoughts or feelings.

As can be seen from the suggested strategies the best response to adolescents is straight forward and honest. Certain behaviors are better to ignore but when needed any behavior can be confronted. Setting limits on what you will tolerate and then following through will go a long way to establishing a sense of clarity and security for the youth. These young people are not fragile and will not break. In fact most of them will appreciate you treating them like you would any adolescent.

Taking Care of Yourself

There is another set of affective responses that the case manager will have to have strategies to deal with. These feelings are ones that the case manager will experience themselves. The following will offer some of the feelings that case managers typically experience and also suggest some strategies to deal with these feelings.

AFFECTIVE CM RESPONSES	CM STRATEGY
Embarrassment.	Tell them. Set limits. Use situation to teach social skills.
Anger.	Keep control. Model ways to handle stress. Stop the activity. Reframe the anger as it relates to the youth's personality.
Frustration.	Complain to peers--use your support groups. Put the situation in perspective.

AFFECTIVE CM RESPONSES	CM STRATEGY
Surprise and shock.	Stay composed at the moment. Figure out how the behavior fits with the situation. Use humor.
Disappointment.	Get a good night's sleep. Reassess expectations. Remind yourself and the youth that it takes time.
Apathy.	Talk with others. Come up with a number of options.
Questioning if what you are doing makes any difference.	Reassess realistically and reset expectations.
Lost; uncomfortable; reaching for straws.	Get other's perspectives. Read.
Over identification with youth.	Self assessment. Be clear of role.
Taking on too much.	Be realistic of the process. Put responsibility back on the youth.

Again, most of the strategies are common sense ways to handle the emotions that case managers are bound to feel in working with adolescents. The use of peers both informally and in a group supervision format can help to give the case manager varying perspectives, options or support. Remembering that each adolescent and their family is unique will assist the case manager in setting realistic expectations.

Some points to remember as case managers follow:

1. Don't personalize what the youth is saying. Many times their comments have nothing to do with you but rather what you represent (adults, parents, etc.).

2. Don't play into power games. Young people are great at getting people into power struggles and then controlling. You can't calm a situation by playing into the problem.

3. Listen to your self and monitor your emotions. There could be many similarities to you and the youth's problem.

4. You are not responsible for anyone but yourself. You do not have to take care of or control the youth's life. If you get into feeling responsible for the youth you will find yourself being angry because of the realization that any blame will be put on you and you'll take it.

5. You're not perfect and all of your decisions are not going to be appropriate. You are trained and competent but that doesn't mean every decision will be appropriate. Decisions aren't right or wrong, they are appropriate or inappropriate. Remember not everyone is going to love you or tell you how wonderful you are. If you get angry when a young person doesn't do this, you're playing a game with them--expecting something for what you're giving.

6. If you don't know what to say, don't say anything.

UNIT 14

The Setting for Program Implementation

Description: This unit describes the type of setting in which contacts should occur during the initial and goal setting phases.

Objectives:

1. Understand the importance of a neutral setting when working with adolescents.
2. Become aware that the setting may confuse others as to the role of the case manager and understand the need to continually clarify that role.

Activities:

1. The instructor should supply the group with five different cases, each placing the adolescent in differing levels of restriction (i.e. group home, hospital). As a group, brainstorm three different activities appropriate for each adolescent.
2. As a group, come up with a clear, concise description of the role of a case manager.

UNIT 14

The Setting for Program Implementation

The initial responsibility of the case manager is to establish a positive and productive relationship with the adolescent. Initially, recreational activities seem to foster an atmosphere effective for relationship building. Ideally, this activity would be on a neutral ground, empowering the adolescent. An example might be a trip to the mall to play video games, bowling, or a trip to the zoo. If, however, the adolescent is housed in a restrictive environment where these activities are not possible, a walk around the grounds or even a game of cards in the client's room would be appropriate.

At this point, a danger exists that the adolescent, the caretakers, and even other professionals may begin to view the case manager as a "friend" or a member of the Big Brothers/Big Sisters organization. While BB/BS is an excellent program and a vital resource, the services provided simply are not those that a case manager provides. For this reason, it is important that the case manager explain his/her role to everyone involved and to continue clarifying that role as needed.

When an effective working relationship has been established, the content of the meetings should shift from recreational to goal setting and implementation. The meeting place should change accordingly. An atmosphere somewhat more private, where work space is available, but that still feels comfortable to the adolescent, is desirable. This may be his/her home, the park, or a restaurant.

The case manager may, however, find it useful to occasionally plan a few more strictly recreational days to keep the adolescent interested and maintain the relationship.

UNIT 15

Service Procedures

Description: This unit provides an example of the procedures necessary in each phase of the program implementation.

Objectives:

1. Understand that service procedures will vary and are contingent upon the setting of the program implementation.

2. List the necessary steps in the implementation of the project at Topeka State Hospital.

Activity: Discuss the necessary procedures in each program phase for your own particular setting.

UNIT 15

Service Procedures

The service procedures for the Family Advocacy Model of Case Management will vary according to the setting in which the program is implemented. The following example reflects the procedures required for the successful implementation of the initial pilot project at Topeka State Hospital and should be used as a guideline for the necessary behaviors in each program phase.

Pre-Program Phase: The case management supervisor will meet with Topeka State Hospital staff to make all formal arrangements necessary to conduct the program from that site. Office space must be assigned for the case managers and supervisor. Key hospital personnel must be informed of the program's goals, objectives, and method of operation. Criteria for selecting cases appropriate for case management services must be clearly outlined and agreed upon. The hospital staff who will be involved in the program will be identified. The importance of their cooperation will be communicated and their questions and concerns responded to. Hospital staff will inform the family of the availability of the case management service and invite/encourage them to participate.

Representatives of the Topeka Area Office of SRS will be contacted to solicit their support for the project. Also, formal arrangements will be made to obtain SRS sanction for continuing case management services following an adolescent's discharge from the hospital.

The K.U. School of Social Welfare Practicum Office will provide the case management supervisors with a list of potential applicants for this practicum site. The Field Liaison and Practicum Instructor will interview and select 4 first level masters students to work as case managers in the project.

Case Manager Training: Training of the case managers will commence during the first week of their practicum. The first full day of training will consist of an orientation to the program model, description of the client population, and examples of past case management work. The training sessions to follow will include an orientation to Topeka State Hospital, meeting key staff at that facility, and assignment of cases. Additional training sessions will be conducted on a consecutive weekly basis to introduce essential components of the program model.

Initial Assessment Phase: The case manager will meet with hospital staff to obtain background information and the staff's assessment of the family's strengths and needs. The case manager will review the family's hospital records for those same purposes.

Initial Contact Phase: The case manager will meet with the adolescent and his/her family members to explain the purpose of the program and to begin establishing a working relationship. Key actors (e.g., SRS worker, teachers, principal, therapists) in the family's efforts to maintain the adolescent in the community will be contacted to introduce the case management program and to solicit their support.

On-going Phase: The case manager will contact by phone and in person the adolescent and his/her family members as frequently as is necessary and appropriate. The purpose of these contacts is to fulfill the program goals. All contacts with key actors in the family's life will take place as needed and will be directed toward that same purpose. Case managers are expected to attend and actively participate in weekly group supervision.

Assessment Phase: The assessment process in this program is on-going. The methods of assessment and their purpose are listed in Unit 16.

UNIT 16

Assessment of Youth's Strengths and Needs

Description: This unit lists and describes the four components of the youth strengths and needs assessment package. Procedures for their use are listed. Guidelines for the worker to keep in mind when using the tools are included.

Objectives:

1. List the four tools used for assessing the youth's strengths and needs.
2. Describe the purpose of each of the tools.
3. Explain how each of the tools are to be used.
4. List the guidelines which will present the tools being used to the detriment of the youth.

Activities:

1. Distribute copies of each of the assessment tools and have the trainees review them.
2. With the trainer assuming the role of family advocate, role play how each assessment tool will be explained to the client.
3. Discuss how information gained from each of the assessment tools can be used by the worker.
4. Discuss procedures for collecting and using the data from the tools for feedback to the program staff.
5. Role play examples of how the guidelines for use of the assessment tools can be implemented with clients.

UNIT 16

Assessment of Youth's Strengths and Needs

The four components of the Youth Strengths and Needs Assessment Package are:

-- Family Identification Form

-- Collateral List and Plan

-- Youth Perspective Checklist

-- Youth Quality of Life Scale

Each of the components is described in this section. Each of the assessment tools is included in the appendices.

1. Family Identification Form

The Family Identification Form is a demographic information sheet. This information can usually be gathered before the initial contact and serves as a reference form. It lists the main persons involved in the youth's living situation and what school the youth is attending.

2. Collateral List and Plan

The Collateral List provides a place to record those persons who provide services to the youth with whom the case manager needs to maintain contact. The purposes of those contacts may include monitoring, advocacy, and communication regarding the youth's needs. The list should be updated as the youth's needs change. The frequency of contact is the contact that the youth has with the resource at a given time. An example would be the youth's school counselor with whom the parent has formal contact on a twice monthly basis. On the same sheet a plan can be described as to how often you will contact the resource for information and to obtain progress reports.

3. Youth Strengths Assessment

The family can be thought of as a system whose function is to serve the individual and collective needs of its members. Functions are the activities the family must perform to meet its needs. Each of the seven family functions is listed in the Youth Strengths Assessment tool. As well as providing a focus for case management activities the assessment can be used to assist the youth to develop an awareness of his or her own

strengths and a beginning understanding of the link between effective functioning and community living.

The Youth Strengths Assessment is to be completed in collaboration with the youth at the outset of case management service. Information should be added and or changed as the youth's strengths and needs change.

4. Youth Quality of Life Scale

The Youth Quality of Life Scale provides the opportunity for the client to assess his or her own quality of life. The scale results should serve as a stimulant for discussion with the youth and as a focus of the case manager's activities.

The scale should be administered at both the outset of the case manager's work with the youth and at termination. The following is a set of guidelines which the case manager should keep in mind when completing assessment tools:

- Move into the assessment after the youth has gotten to know you and the interaction feels comfortable. This point may be reached after a few hours or a number of weeks.

- When discussing an item that may be awkward or embarrassing, attempt to maintain a matter-of-fact composure.

- Keep the meeting informal and the interview semi-conversational.

- At times the youth may tend to ramble or over elaborate. If it becomes counter-productive to the assessment attempt to refocus on the tasks at hand without being rude.

- Be prepared to explain meanings of words and to rephrase questions.

- Do not assume that the client has adequate reading skills to complete the assessment on their own.

- Be certain the client understands the assessment tool is not a test which they can pass or fail.

- Be patient. The full assessment does not have to be completed during the first meeting.

UNIT 17

Key Actors in the Family Advocacy Case Management Model

Description: This unit provides an example of every party's involvement in the program and the responses required of them for program success.

Objectives:

1. Understand that key actors will vary and are contingent upon the setting of the program implementation.

2. List the key actors and their necessary responses for the successful program implementation at Topeka State Hospital.

Activity: Discuss the key actors and their necessary responses for your own particular setting.

UNIT 17

Key Actors in the Family Advocacy Case Management Model

Key Actors

The specific key actors important in the program implementation are also dependent upon the program setting. As with the previous unit, the following should be viewed as an example. An explanation of each party's involvement and the responses required of them for program success are included.

A) The adolescent's primary treatment provider in the hospital, most often a psychiatrist, plays the major gate keeping role. It is this person who ultimately determines when an adolescent is to be returned to the community. What is more, his/her approval is necessary for a family to be assigned to the case management program.
Required Responses: Approval for assignment of case managers; Designation of trial visit and/or discharge dates;

B) The Topeka State Hospital social worker who has the adolescent's family in his/her case load must provide the case manager the initial access to the adolescent and the family. The social worker also plays a role as part of the hospital treatment team in assigning a family to the program. It is the social worker who can legitimize the case management role to other hospital staff and SRS workers.
Required Responses: Provide access to adolescents and family members; Encourage hospital staff to cooperate;

C) The ward staff at TSH are responsible for the day-to-day well being of the adolescents. It is the ward staff who actually control the comings and goings of their charges. Given their unique position, these workers can provide valuable insight into the youths' strengths and needs.
Required Response: Allow the case manager access to the adolescents; Provide information re: their strengths and needs;

D) The Kansas Social and Rehabilitation Services (SRS) worker plays a key role in the family's life if the adolescent is in state custody. Ultimately, this worker can determine when and whether the adolescent will be returned home. The SRS worker also can authorize state funding for services needed by the family;

Required Responses: Provide funding for needed services;

E) Each adolescent is enrolled in an educational setting. This setting may be within the hospital or in the normal public school system. Regardless of its location, the adolescent's teacher(s) is a key to him/her remaining in the community. Unless the adolescent can function successfully in the school setting he/she is likely to be readmitted to the hospital.
Required Responses: Provide an educational environment most conducive to meeting the adolescents needs;

F) In order for the care takers to maintain the adolescent in the community they will need to make use of a variety of resources (e.g., YWCA, YMCA, Community Theatre, Parent Support Group, Recreation Department). The cooperation of the staff responsible for those services will be essential if the family is to gain access to them.
Required Responses: Providing the adolescent and family members access to needed services;

G) It is the care takers themselves who are most critical to program's success. Their participation, and that of the adolescent, is contingent upon their approval. Their on-going interest in the program and their willingness to work with the case manager are essential if the program is to be effective. Furthermore, the care taker's feedback to hospital staff has considerable influence upon the latter's attitude toward the program. The care givers play a direct role in program evaluation through completion of assessment instruments.
Required Responses: Willingness and desire to maintain the adolescent in the community; Willingness to communicate and cooperate with the case manager; Provide feedback regarding program effectiveness.

UNIT 18

Assessing and Developing Independent Living Skills

Description: This unit describes the importance of teaching adolescents independent living skills and provides examples of personal instruction in this area.

Objectives:

1. Understand how important it is to teach emotionally disturbed adolescents the skills required for independent living.
2. Identify the barriers which often prevent the instruction of these skills.
3. Understand how a case manager can be useful in this area.

Activities:

1. Have the group decide upon a number of independent living skills they take for granted as common knowledge. List the steps necessary in teaching adolescents with emotional problems these skills.

UNIT 18

Assessing and Developing Independent Living Skills

As most children age, they slowly learn the skills necessary to eventually lead an independent life. Generally, these skills are taken for granted in adulthood. Few remember being taught to balance a checkbook, or even opening their first back account for that matter. The fact remains, however, that these are learned behaviors.

For youth with emotional disabilities, so much emphasis is placed on their emotional problems that the teaching of these skills is often greatly reduced if not totally neglected. Parents may feel that their child is not capable of learning such skills, or their energy may be so depleted from coping with their child's disability that they simply cannot perform the necessary skill building tasks. Youth with emotional problems, too, may have a greater difficulty learning self-sufficiency skills, requiring more time to be spent breaking the skills down into smaller tasks and more opportunities to practice their use.

Youth who do not have a family of origin to help prepare them for self-sufficiency face even greater problems and challenges. These youth frequently suffer from decreased feelings of self-worth and competence as a result of being placed in substitute care. For some youth, their family of origin did not have the resources to teach the beginnings of problem solving, decision making or daily living skills. Parenting for those who have experienced several substitute care placements is likely to have been loving and caring but uneven in the preparation for self-sufficiency. These youth have not had the continuity required to learn and develop independence.

For youth in substitute care, the preparation for independence received prior to discharge is varied. According to Cook and Ansell (1986), 63% of youth in four states had received no independent living services. The service most likely to be provided to youth in substitute care is psychological counseling (45%). Only four other services were provided to at least 35% of the youth (social skills, job search information, sex and birth control information and budgeting skills). The "service area in which youth were provided the most experience before discharge was employment (62% of the youth had at least one job while in care)" (p. 7), although it was difficult for youth to maintain a job. In addition, "youth in care were discharged with minimal experience in living on their own (15% had experienced independent living arrangements). This lack of

preparation included a lack of training in basic living skills, no high school diploma, and/or lack of a support system to turn to once they were discharged" (Cook & Ansell, 1986, p. 7).

While for all youth with emotional disabilities counseling and employment are needed, it is apparent that more attention needs to be given to other areas as well. Turnbull and Summers (1984), among others, suggest that when people know how to function in a set of life domains they have more satisfying and productive lives. As stated in Unit 8, these domains include affection (companionship, intimacy, expressing emotions), education (school work, continuing education), domestic (provision of food, clothing, transportation, home maintenance), health (adequate health care, nutrition), economic (generating income, budgeting), recreation (effective use of leisure time, hobbies), and socialization (interpersonal relationships, social skills). To become independent, youth need preparation in all of these life domains.

It is the case manager's job, then, to assess the adolescent's capabilities in each of these domains and then to assist the adolescent in the development of these independent living skills. While the assessment of strength and need areas in the seven life domains has been previously discussed, the development of these skills requires two distinct actions. In some areas resource acquisition (discussed in further detail in Unit 14) may be appropriate, as, for example, the Topeka Youth Project which offers classes in successfully gaining and maintaining employment. Other areas, however, could require personal instruction. The following are examples of this type of skill development.

Life Domain: Domestic

> A twelve year old client had told the case manager her father had given her money for a haircut. Upon their next meeting the case manager noticed that the client had not received this haircut. After discussing this it became clear that she did not know how to go about making an appointment. Together they went through the yellow pages. They picked out three places within walking distance or close enough to ride her bike. They called all three to check the prices. After deciding on one, they called back and set up an appointment.

Life Domain: Economic

> A seventeen year old client wanted to get a part-time job, and did not want to wait for the next set of classes at the Topeka Youth Project. The case manager went through the want ad. The adolescent circled three jobs he thought he would like. The case manager went through and discussed with the client his interests in these

jobs, the duties they would require, and whether the adolescent thought he would be able to get these jobs. The case manager picked up an application from a nearby fast food restaurant and helped the adolescent fill it out. They discussed proper dress for an interview and even held a mock interview.

Some of the material for this unit has been adapted from: *Together to self sufficiency: An independent living lifebook covering employment and health.* John Poertner, Project Director, Laurie Knutson, Author. The University of Kansas, School of Social Welfare, Lawrence, Ks., 66045.

UNIT 19

Making the Most of Group Supervision

Description: This unit describes the advantages of group supervision and the skills necessary to make group supervision successful.

Objectives:

1. List the advantages of group supervision.
2. Understand what skills a case manager must possess to make the group work for him or her.

Activity: Discuss how the group has been useful during training and compare to the advantages listed in this unit.

UNIT 19

Making the Most of Group Supervision

Encompassed in the Family Advocacy Model of Case Management is the concept that group supervision enhances instruction, facilitates learning, and offers the case manager many advantages over the traditional one on one type supervision.

Personal supervision limits the case manager to the ideas, suggestions and experience of one person. Group supervision widens the possibilities in all these areas.

> Julie was having problems confronting an adolescent client about her explicit language and sexual discussions. Another member of the group shared her similar experience and the techniques she had successfully used. Julie did not feel completely comfortable with the suggestions, saying that the behavior was not compatible with her personality. The group brainstormed different solutions, each member adding his/her ideas and experiences. The supervisor added suggestions and helped to sort out the solutions into a theoretical framework. In the end, Julie decided upon a plan of action which was a compilation of her peers' and the supervisor's ideas.

The group, then, combines learning from authority, as well as learning from other case managers. It provides the case manager with a wealth of experiences and perspectives. Within the group, the case manager can observe many diverse ways of dealing with situations and model those behaviors which he/she feels are both personally and professionally appropriate.

Along with the learning of professional skills, the group also provides an opportunity for interpersonal learning. This learning will enhance many of the skills necessary in working with the adolescent. For example, as the group brainstorms solutions, the case manager is learning effective problem solving methods. Other important skills in which learning is facilitated through group participation are effective listening, empathetic responding, and confrontation.

Perhaps the most vital function of the group is that of support. The group is a place where the case manager receives the too often forgotten pat on the back for a job well done. Even more important, the group can reframe what the case manager feels is a failure, to point out the strengths in the case manager's actions. Within the group it is okay to make mistakes, because mistakes are a learning experience. The group should foster a sense of belonging and provide the case manager with the confidence that accompanies the knowledge that others support one's decisions. Another advantage of this type of supportive atmosphere is that it provides the case manager with the

opportunity to experiment with different behaviors and interventions without any fear of failure.

The most practical function of the group, however, is the sharing of information. Each member will bring to the group personal knowledge and expertise. One such group was comprised of a lawyer, a case manager with a degree in early childhood education, one with a dual degree in social work and psychology, another with a bachelor's degree in psychology and a supervisor working on his Ph.D. in social work. Each was able to provide the group with useful information on such topics as educational rights, abortion, abuse and neglect, etc. Along these lines is the potential for a much broader knowledge base concerning community resources. Each case manager is continually accessing resources for clients which may prove useful to others in the group. For example, one member of the group felt that for her adolescent client to remain in the home, the parents would need an occasional break from their child. Another case manager had recently experienced the same problem, and was able to provide the group with the phone number of the Kansas Children's Service League which provides respite care for families with these needs.

While the group does offer these advantages, it is the case manager's responsibility to get what he/she needs from each meeting. The most important skill here is being able to generalize each case manager's experience to one's own clients.

> When Julie was having problems confronting her adolescent client, Tony was experiencing problems confronting a client's mother about her obvious ambivalence to her son's return home. The group generated many ideas and discussed confrontation skills to help Julie. While some of these were appropriate only for an adolescent client, others were useful for adults as well, and Tony was able to draw what he needed from the discussion.

This skill is vital to the case manager's effective participation in group supervision. Because of time limitations, if the case manager is not able to generalize in this manner, he/she will most likely feel that not enough time is spent on his/her issues. If, however, the case manager is experiencing a problem which has not been discussed, it is once again his/her responsibility to say, "I have a problem which has not been addressed and I really need to talk about it." A group, then, can be an excellent form of supervision as long as the case manager uses the proper skills and takes the initiative to receive effective feedback.

REFERENCES

Ansell, D., & Cook, R. (1986, June). *Independent living services for youth in substitute care.* Submitted to the Department of Health and Human Services, Administration for Children, Youth and Families.

Cutler, D. (1981). The chronically mentally ill. In W. Silverman (Ed.), *Community mental health.* New York: Praeger.

Florida Mental Health Institute. (1986-87). Program Update: Case Management. *Update, 2*(2), 10-12.

Friedman, R.M. (1984). *Seriously emotionally disturbed children: An underserved and ineffectively served population.* Florida Mental Health Institute.

Gilmore, M., Cheng, C., & Coron, D. (1984). *Defining and counting mentally ill children and adolescents.* NIMH Commission Paper.

Harrod, J.B. (1986). Defining case management in community support systems. *Psychosocial Rehabilitation Journal, 9*(3), 56-61.

Intagliata, J. (1982). Improving the quality of care for the chronically mentally disabled: The role of case management. *Schizophrenia Bulletin, 8*(4).

Isaacs, M.R. (1983). *A description of five state programs to improve service delivery systems for severely emotionally disturbed children and adolescents.* NIMH Commissioned Paper.

Johnson, P.J., & Rubin, A. (1983). Case management in mental health: A social work domain? *Social Work, 28*, 48-55.

Knitzer, J. (1982). *Unclaimed children.* Washington, DC: Children's Defense Fund.

Lourie, I.S., & Katz-Leavy, J. (1987). *Severely emotionally disturbed children and adolescents.* Report. Washington, DC: National Institute of Mental Health.

Normal, L. (Ed.). (1987). *Taking charge: A handbook for parents whose children have emotional handicaps.* Portland: Portland State University.

Rodwell, M., Bridgeman, J., Donner, R., Hanson, J., Petr, C., & Presley, J. *Policy analysis: Mental health policy for children and youth.* University of Kansas, School of Social Welfare, Lawrence, KS.

Strauss, J.S., Downey, T.W., & Sledge, W.H. (1979). Intensive psychiatric care for adolescents and young adults. *Hospital and Community Psychiatry, 30*(2), 122-125.

Turnbull, A.P., Summers, J.A., & Brotherson, M.J. (1984). *Working with families with disabled members: A family systems approach.* University of Kansas Research and Training Center on Independent Living, Lawrence, KS.

Wasylenki, D.A., Goering, P.N., Lancee, W.J., Ballantyne, R., & Parkas, M. (1985). Impact of a case manager program on psychiatric aftercare. *The Journal of Nervous and Mental Disease. 173*(5), 303-308.

Weil, M., & Karls, J.M. (1985). *Case management in human service practice.* San Francisco: Jossey-Bass.

APPENDICES

ASSESSMENT TOOLS

CASE MANAGEMENT FAMILY'S PERSPECTIVE FORM

DEMOGRAPHIC INFORMATION

Name _____ Birth Date _____ Race _____

Parent(s)/Guardian's name _____

Marital Status _____ How long? _____ Religion _____

If parent(s) absent:

Name _____ Relationship _____

Address _____

Name _____ Relationship _____

Address _____

If parent deceased - name and date _____

Adults involved in care of child:

(Parent(s), step parent(s), foster parent(s), grandparents, babysitter, etc.)

Name	Relationship	Address	Phone

Other members living in household:

Name	Relationship	Address	Phone

Child's School _____ Grade _____

CASE MANAGEMENT COLLATERAL LIST AND PLAN

CASE NAME _____ CASE MANAGER _____

PERSON/AGENCY PHONE NUMBER	FREQUENCY OF CONTACT	PLAN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

9/86 PD

YOUTH CASE MANAGEMENT PERSPECTIVES FORM

Education

EVIDENCE FROM YOUTH'S PERSPECTIVE

Is youth in school? (What program?)

STRENGTHS _____

_____

NEEDS _____

_____

Is youth satisfied with his/her educational program?

STRENGTHS _____

_____

NEEDS _____

_____

Does youth think that the individual educational plan meets his/her needs?

STRENGTHS _____

_____

NEEDS _____

_____

In what school activities is youth involved?

STRENGTHS _____

_____

NEEDS _____

_____

Is youth satisfied with parents' school involvement?

STRENGTHS _____

_____

NEEDS _____

_____

Employment needs

Does youth want a job? (Part-time, full time, volunteer?)

STRENGTHS _____

_____

NEEDS _____

_____

EVIDENCE FROM YOUTH'S PERSPECTIVE

What skills does youth have? STRENGTHS _____

_____

NEEDS _____

_____

What would youth like to do? STRENGTHS _____

_____

NEEDS _____

_____

Recreation needs

What does youth like to do? STRENGTHS _____

_____

NEEDS _____

_____

What does youth do in his/her free time? STRENGTHS _____

_____

NEEDS _____

_____

What would youth like to do that he/she is not currently doing? STRENGTHS _____

_____

NEEDS _____

_____

Domestic/health

What does the youth eat? STRENGTHS _____

_____

NEEDS _____

_____

EVIDENCE FROM YOUTH'S PERSPECTIVE

What is his/her eating pattern?

STRENGTHS _____

NEEDS _____

Does youth think this is adequate?

STRENGTHS _____

NEEDS _____

Is clothing satisfactory?

STRENGTHS _____

NEEDS _____

Are medical needs adequately attended to?

STRENGTHS _____

NEEDS _____

Is dental care adequate?

STRENGTHS _____

NEEDS _____

Does transportation meet needs?

STRENGTHS _____

NEEDS _____

	EVIDENCE FROM YOUTH'S PERSPECTIVE
Is housing adequate (space, safety, cleanliness)?	STRENGTHS _____
	_____
	NEEDS _____
	_____
Economic	
Does youth have enough money to meet his/her needs?	STRENGTHS _____
	_____
	NEEDS _____
	_____
Is youth satisfied with how he/she manages their money?	STRENGTHS _____
	_____
	NEEDS _____
	_____
Socialization	
What social activities does youth attend?	STRENGTHS _____
	_____
	NEEDS _____
	_____
What is youth's perspective on his/her participation?	STRENGTHS _____
	_____
	NEEDS _____
	_____
What social activities would youth like to participate in that he/she is not currently doing?	STRENGTHS _____
	_____
	NEEDS _____
	_____

EVIDENCE FROM YOUTH'S PERSPECTIVE

Who are the youth's best friends?

STRENGTHS _____

_____

NEEDS _____

_____

Does youth have enough close friends?

STRENGTHS _____

_____

NEEDS _____

_____

Affection

What adults does youth define as important?

STRENGTHS _____

_____

NEEDS _____

_____

In what ways are these people important?

STRENGTHS _____

_____

NEEDS _____

_____

How does youth get along with family members?

STRENGTHS _____

_____

NEEDS _____

_____

Does youth feel loved?

STRENGTHS _____

_____

NEEDS _____

_____

EVIDENCE FROM YOUTH'S PERSPECTIVE

Does youth get the comfort and reassurance he/she needs?

STRENGTHS _____

_____

NEEDS _____

_____

Does youth express loving feelings to his/her satisfaction?

STRENGTHS _____

_____

NEEDS _____

_____

Does youth feel needed and worthwhile?

STRENGTHS _____

_____

NEEDS _____

_____

YOUTH QUALITY OF LIFE ASSESSMENT SCALE

Please indicate how well you are doing for each of the following.

	Circle your answer.					
	Very Well					Not Very Well
Your education at school.	1	2	3	4	5	6
Having adequate transportation.	1	2	3	4	5	6
Having adequate food and nutrition.	1	2	3	4	5	6
Having adequate clothing.	1	2	3	4	5	6
Managing the money you have.	1	2	3	4	5	6
Having enough money to meet your needs.	1	2	3	4	5	6
Getting adequate medical care.	1	2	3	4	5	6
Getting adequate dental care.	1	2	3	4	5	6
Feeling safe and secure.	1	2	3	4	5	6
Feeling loved.	1	2	3	4	5	6
Feeling good and secure about the future.	1	2	3	4	5	6
Finding and keeping a job.	1	2	3	4	5	6
Having strong, close relationships.	1	2	3	4	5	6
Getting comfort and reassurance.	1	2	3	4	5	6
Being able to express loving feelings.	1	2	3	4	5	6
Getting along with family members.	1	2	3	4	5	6
Needing other people.	1	2	3	4	5	6
Having close friends.	1	2	3	4	5	6
Attending social events.	1	2	3	4	5	6
Having fun and recreation.	1	2	3	4	5	6
Getting enough rest and relaxation.	1	2	3	4	5	6
Enjoying a hobby.	1	2	3	4	5	6

	Circle your answer.					
	Very Well					Not Very Well
Feeling good about yourself.	1	2	3	4	5	6
Recognizing your own strengths.	1	2	3	4	5	6
Feeling good about home and family.	1	2	3	4	5	6
Feeling needed and worthwhil	1	2	3	4	5	6

OUTCOME MONITORING TOOLS

CASE MANAGER CONTACT SHEET/TIME LOG . (11-87)

CASE MANAGER: _____ WEEK OF _____

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY
9:00 A.M.	9:00	9:00	9:00	
10:00	10:00	10:00	10:00	
11:00	11:00	11:00	11:00	
12:00 P.M.	12:00	12:00	12:00	
1:00	1:00	1:00	1:00	
2:00	2:00	2:00	2:00	
3:00	3:00	3:00	3:00	
4:00	4:00	4:00	4:00	
5:00	5:00	5:00	5:00	
6:00	6:00	6:00	6:00	
7:00	7:00	7:00	7:00	
8:00	8:00	8:00	8:00	

AGENDA (9-8-87)

Life Domain: Date:

Goal and Steps Toward Achievement	Responsibility for Activity C or CM	Date Accomplished	Comments

Client Signature

Case Manager Signature

CLIENT SATISFACTION MEASUREMENT TOOL

SURVEY OF YOUTH'S SATISFACTION WITH CASE MANAGEMENT SERVICE

Client: _____ Case Manager: _____

Date Completed: _____

By completing this survey you will help us determine if case management is working. After you complete the survey please mail it in the envelope which was given to you.

Please indicate the extent to which you agree or disagree with each of the following statements. Circle one number for each statement.

1. While receiving case management services I have learned useful information about my emotional problems.

Strongly Agree					Strongly Disagree
1	2	3	4	5	6

2. While receiving case management services I have learned some ways to keep my emotional problems from causing me big problems.

Strongly Agree					Strongly Disagree
1	2	3	4	5	6

3. I feel that my case manager really wants to help me.

Strongly Agree					Strongly Disagree
1	2	3	4	5	6

4. My case manager has helped me learn the skills I will need as an adult to live on my own.

Strongly Agree					Strongly Disagree
1	2	3	4	5	6

Additional comments:

STAFF MORALE TOOLS

CASE MANAGER'S AGENDA FOR CASE DISCUSSIONS (10-87)

The following items should be the focus when presenting cases for discussion and feedback.

1. FOCUS ON STRENGTHS TO IDENTIFY GOALS.

2. KEEP IN MIND THE ADOLESCENT'S EVENTUAL NEED TO DEVELOPE SKILLS FOR INDEPENDENT LIVING.

3. ALWAYS EXPLORE THE POTENTIAL FOR USE OF NATURAL HELPERS AND COMMUNITY RESOURCES WHEN ESTABLISHING GOALS.

4. FOR EACH CLIENT GOAL OR NEED AREA BRAINSTORM AT LEASE 3 ALTERNATIVES TO FULFILL THE NEED.

5. MAKE IT YOUR GOAL TO LEAVE THE SESSION WITH A PLAN OF ACTION FOR EACH OF YOUR CASES--INCLUDING SPECIFIC STEPS TO BE TAKEN BY THE CM.

WORKER'S GROUP SUPERVISION ASSESSMENT (5-86)

(To be completed by each worker at the end of group supervision sessions

CIRCLE YOUR RESPONSE

1. The session started on time.	YES	NO
2. The seating arrangement allowed each person to be clearly seen.	YES	NO
3. Interruptions occured during the session.	YES	NO
4. Each group member was involved in the discussion.	YES	NO
5. Everyone contributed ideas and suggestions.	YES	NO
6. The atomosphere in the group was optimistic and positive.	YES	NO
7. Each person laugned at some point during the session.	YES	NO
8. Conscientious efforts that failed were celebrated.	YES	NO
9. References were made to problems, illness, or diagnoses during the session.	YES	NO
10. Common characteristics or patterns among cases were identified.	YES	NO
11. I feel like I know what to do next?	YES	NO
12. At the end of the group session I felt energized and hopeful.	YES	NO

Additional comments:

SUPERVISOR'S ASSESSMENT OF GROUP SUPERVISION SESSION

(To be completed by the supervisor following each group session)

1. WHICH CASES WERE REVIEWED?

2. WHICH WORKERS WERE NOT INVOLVED IN THE GROUP PROCESS?

3. WHO APPEARED NEGATIVE ABOUT CLIENTS OR ATTEMPTED TO SHOOT DOWN A CREATIVE IDEA OR POTENTIAL RESOURCE?

4. WHO ADMITTED A MISTAKE?

5. HOW WERE "MISTAKES" CELEBRATED?

6. WHAT NATURAL HELPERS AND/OR COMMUNITY RESOURCES WERE IDENTIFIED FOR EACH CASE?

7. HOW DID THE SUPERVISOR REFRAME PROBLEM STATEMENTS OR DIAGNOSTIC LABELS INTO STRENGHTS OR GOAL STATEMENTS?

8. WHAT PATTERNS OF WORKER BEHAVIOR, FRUSTRATIONS/STRUGGLES SUCCESSES/ET
CAN BE IDENTIFIED FROM CASE SPECIFICS?

9. WHO RECEIVED POSITIVE FEEDBACK FOR:

RECOGNITION AND/OR USE OF ADOL/FAMILY STRENGTHS

IDENTIFICATION AND USE OF NATURAL/COMMUNITY RESOURCES

CLIENT ACHIEVEMENTS AND GOAL ATTAINMENT

10. WHAT UNMET FAMILY NEEDS OR UNAVAILABLE COMMUNITY RESOURCES WERE
IDENTIFIED? WHAT CAN BE DONE TO MEET THESE NEEDS?

11. WHICH WORKER SEEMED DEFENSIVE OR FRUSTRATED? WHAT ATTEMPTS WERE MAD
TO ESTABLISH MORE REALISTIC EXPECTATIONS OR TO BREAK DOWN TASKS
INTO SMALLER STEPS?

COMMON CHARACTERISTICS EXHIBITED BY YOUTH WITH EMOTIONAL DISABILITIES

COMMON CONDITIONS EXHIBITED BY YOUTH WITH EMOTIONAL DISABILITIES

Some of the youth with whom case managers work will have received a diagnostic label, such as "conduct disorder", from the mental health service system. Consistent with the strengths approach the Family Advocacy model does not emphasize the client's diagnosis. However, it is important for the case manager to know the meaning and implications of such labels for a variety of reasons. Often the youth's family members have only a superficial understanding of their child's problems. The incomplete and sometimes inaccurate information which they do have only increases their anxiety and sense of hopelessness. This information gap also makes it difficult for the care givers to be effective advocates for their child. The case manager can be of great assistance by helping the family obtain accurate and understandable information. Secondly, by learning about the behaviors which may go along with particular diagnoses, the family advocate can help parents, teachers, and other care givers provide the most effective care to the youth. For example, youth who are taking medication to control their behavior may be tired or have unusually short attention spans caused by the medicine. Knowing this the youth's teacher can set their classroom expectations accordingly. Also, knowing what kind of medicine the individual is taking and its possible side effects allows teachers and parents to monitor its effectiveness and inform mental health providers when problems occur. A third reason for family advocates to be knowledgeable about the youths mental health diagnosis is to enable them to communicate with members of the mental health service system who refer to diagnostic labels.

It is important to emphasize that in the Family Advocacy Model of Case Management the youth should never be thought of as a diagnostic label (e.g., "that schizophrenic"). But for all the reasons noted above its important for the family advocate to be knowledgeable about the common diagnoses given to youth with emotional disabilities. The information included in the remainder of this section, "Common Conditions Exhibited by Children and Youth with Severe Emotional Disturbance,"* should help in gaining that knowledge. The family advocate should always coordinate with the family's mental health treatment providers before discussing the youth's diagnosis with family members.

*The material which follows is contained in:

Taking Charge: A Handbook for Parents Whose Children Have Emotional Handicaps, 1987.

Published and reprinted here with the permission of:

Family as Allies Project
Research and Training Center to Improve Services
for Seriously Emotionally Handicapped Children
and Their Families
Regional Research Institute for Human Services
Portland State University
Portland, Oregon 97207-0751
(503) 464-4040

The newsletter, *Focal Point*, is available free of charge from the above address.

Source:
Taking Charge: A Handbook for Parents Whose Children Have Emotional Handicaps. Families as Allies Project, Research and Training Center to Improve Services for Seriously Handicapped Children and Their Families, Portland State University, 1987

SECTION TWO: COMMON CONDITIONS EXHIBITED BY CHILDREN AND YOUTH WITH SEVERE EMOTIONAL DISTURBANCE

The American Psychiatric Association has developed a classification system for mental illnesses. The latest revision of this classification, the *Diagnostic and Statistical Manual of Mental Disorders (3rd Ed. Revised)* (DSM-III(R)), includes a category of disorders first evident in infancy, childhood or adolescence. Below are descriptions of some of these disorders with brief, identifying definitions. For more information about these and other disorders, consult the references/bibliography pages at the end of this chapter.

BEHAVIOR DISORDERS

ATTENTION DEFICIT DISORDER. Attention deficit disorder (ADD) is a condition characterized by a failure to remain attentive in various situations, especially in the school and home. Individuals with ADD may or may not also exhibit excessive motor activity called hyperactivity. Current thinking emphasizes that the causes of ADD are likely to be biological. Treatment of choice for ADD is often the use of stimulant medications like Dexedrine, Ritalin or Cylert.

CONDUCT DISORDER. The term conduct disorder is used to refer to young persons who have shown a repetitive and persistent pattern of conduct which violates either the basic rights of others or age-appropriate social norms or rules.

Children with "unsocialized conduct disorders" are described as failing to establish a normal degree of affection, empathy, or bond with others. They may have superficial peer relationships, be egocentric and manipulative, lack concern for the welfare of others and be without guilt or remorse.

The more socialized types of young persons with conduct disorders are described as being capable of attachment to others, such as to peers, but they resemble the undersocialized types by being callous or manipulative toward persons to whom they are not emotionally attached.

Children with aggressive conduct disorders are characterized by physical violence against others, ranging from vandalism, firesetting and burglary to rape and murder. The non-aggressive child with a conduct disorder may break rules at home or at school and may be truant, a substance abuser, or a runaway.

EMOTIONAL DISORDERS

ANXIETY DISORDERS. Anxiety disorders refer to any of a number of exaggerated or inappropriate responses--affective (emotions), cognitive (thinking), motor (movement) or physiological (physical symptoms)--to the perception of external or internal danger.

SEPARATION ANXIETY. School phobia is a form of separation anxiety brought about by the necessity of leaving home and family members to attend school. It is usually a situational problem, but can be a serious psychiatric emergency if not dealt with when it first occurs. When children with school phobia refuse to go to school, they may panic unless permitted to stay at home. The longer the children are permitted to stay out of school, the more severe are their social and educational impairments.

AVOIDANT DISORDER. Children and adolescents with avoidant disorders timidly avoid the establishment of new interpersonal contacts or ordinary relationships with strangers to an extent that there is noticeable interference with development of peer relationships and general social functioning. On the other hand, such children may enjoy relationships at home or with familiar persons and may seek new social relationships when non-threatening conditions exist.

OVERANXIOUS DISORDER. Children with this disorder have diffuse fears and worries that cannot be traced to specific problems or stresses. They worry excessively about examinations, potential injuries, friendships or group acceptance. Their anxiety may be expressed in various physiological symptoms such as headaches, respiratory distress and other recurring problems.

OTHER DISORDERS OF INFANCY, CHILDHOOD OR ADOLESCENCE

SCHIZOID DISORDER. The essential features of schizoid disorder are difficulty in forming social relationships, introversion, bland or constricted affect (expression of feelings). Children with this disorder show little desire for social involvement, prefer to be "loners," and have few, if any, friends. When placed in social situations, they are inept and awkward. Their friendships tend to be with younger or other poorly functioning youngsters.

Schizoid children may do poorly academically, despite average or superior intelligence, because of withdrawal from the real world to fantasies and preoccupation with narrow interests, such as prehistoric animals or spaceships. They are rigid in defense of their ideas and pursuits, are obstinate, and have aggressive outbursts in response to pressure to adapt to external demands. Schizoid children do not complain of loneliness nor are they usually bored. They display more discomfort when their isolated routine is interrupted than when they are in their "own world."

OPPOSITIONAL DISORDER. Children with an oppositional disorder display their aggressiveness by patterns of obstinate, but generally passive behavior. They appear to be conforming, but they continually provoke adults or other children. By the use of negativism, stubbornness, dawdling, procrastination, and other measures, they covertly show their underlying aggressiveness.

IDENTITY AND ADJUSTMENT DISORDERS OF ADOLESCENCE. It is difficult for trained professionals as well as for parents to differentiate between adjustment disorders of adolescence and normal psychological changes and concerns which occur during this stage of development. All adolescents experience some stress as they face the issues of establishing independence from family and personal

identity in the adult world. Some adolescents, however, experience extreme anxiety, depression, eating and sleeping disorders, clinging to peers and parents, psychosomatic disorders, or impulsive acting out. These more extreme reactions represent ineffective attempts at coping with becoming an adult.

Characteristics of adolescent adjustment disorders may include:

1. Impairment in the normal level of social, educational and occupational functions;
2. Difficulty in making decisions;
3. Increased dependence on or rejection of parental advice and values;
4. Newly developed and unwarranted concern about parental possessiveness;
5. Overdependence on peers;
6. Conflicting feelings between wanting to stay and leaving the home;
7. Depressed mood;
8. Anxious mood;
9. Acting-out; and
10. Uncharacteristic inhibition at school or at work.

To qualify as an adjustment disorder the above symptoms must be present repeatedly and are subject to resolution if the youth is relieved of a particular stress or achieves a new level of adultlike behavior.

DEVELOPMENTAL DISORDERS

PERVASIVE DEVELOPMENTAL DISORDER. The term pervasive developmental disorder refers to a group of conditions marked by distortions, deviations and delays in the development of social and motor skills, language, attention, perception, and reality testing.

INFANTILE AUTISM. Infantile autism begins before the age of 30 months and is characterized by a failure to develop the usual relatedness to parents and other people. As infants, these children may lack a social smile, avoid eye contact, and fail to cuddle. These children also fail to develop normal language and may use non-verbal commands in place of speech. Some autistic children develop echolalia; that is, the meaningless repetition of what is said by others.

The activities and play schemes of the autistic child are rigid, repetitive, and lack variety. Autistic children may manifest over- or under-responsiveness to sensory stimuli, for example to sound or pain.

The intellectual functioning of autistic children may range from profoundly retarded to normal levels. About 50 percent of autistic children are moderately, severely or profoundly retarded. Another 25 percent are mildly retarded and 25 percent have I.Q.'s of 70 or more.

CHILDHOOD ONSET PERVASIVE DEVELOPMENTAL DISORDER. This refers to a group of conditions marked by distortions, deviations, and delays in the development of social and motor skills, language, attention, perception, and reality testing that begin after the age of 30 months and by the age of 12.

ARE AUTISTIC CHILDREN CONSIDERED SEVERELY EMOTIONALLY DISTURBED?

Autism has been recognized as a separate illness or condition for approximately 40 years. During this period, professionals' conceptions of autism have changed dramatically. When Leo Kanner first identified infantile autism in 1943, he regarded the autistic child's "inability to relate...in the ordinary way to people and situations from the beginning of life" to be the characteristic which distinguished autism from schizophrenia and other types of psychosis. Kanner considered autism to be a mental illness and suspected that, because autism had not been distinguished from schizophrenia and other mental disorders, it was actually a more common problem than previously suspected.

Despite Kanner's warnings, confusion in distinguishing between autism and schizophrenia continued. In 1952, psychotic reactions in children, meaning primarily autistic-like symptoms, were classified in the *Diagnostic and Statistical Manual of Mental Disorders-I* under "schizophrenic reaction, childhood type."

In the 1960's in England, psychiatrists developed nine criteria for diagnosing psychosis in childhood. These nine points were very similar to the criteria Kanner had used for autism, resulting in confusion as to the difference between autism and childhood psychosis. Among professionals, an argument developed over whether autism was a separate mental illness or merely the early stages of psychosis or schizophrenia.

The causes of autism were as unclear as its definition. Kanner's original thought was that autism was a distinct illness caused by family interactions involving parents who lacked warmth and were preoccupied with intellectual abstractions. Kanner believed, however, that autism had some biological, as well as psychological, basis.

On the other hand, Bettelheim adhered to a psychodynamic explanation of autism which blamed the "refrigerator" mother--mothers who lacked warmth and motherly instincts--for causing normal infants to withdraw into autism.

Recent studies comparing parents of autistic children to parents of normal children have not shown significant differences or deficits in infant and child rearing skills. Thus, Bettelheim's "refrigerator mother" and psychoanalytical treatment model for autism have been largely discounted. Today there is mounting evidence that autism is a distinct physical condition whose origins probably lie in biological, rather than emotional, abnormalities. Thus, autism is now considered to be a physical condition resulting in abnormal behavior and mental development.

DISORDERS OF ADOLESCENCE

SCHIZOPHRENIC DISORDERS. Schizophrenia is a broad term encompassing a number of clusters of symptoms which may vary over time. In general, the term refers to a psychotic disorder characterized by loss of contact with environment

and by disintegration of personality. Symptoms of the illness may include: hearing one's thoughts spoken aloud, auditory hallucinations that comment on the individual's behavior, imagined illnesses or pains, the experience of having one's thoughts controlled, the spreading of one's thoughts to others, delusions, and the experience of having one's actions controlled or influenced from the outside. The onset of schizophrenia usually occurs in young adulthood but symptoms can develop in individuals as young as 15.

ANXIETY DISORDERS.

Phobic Disorder. A phobic disorder is characterized by persistent irrational fears of a specific object, activity or situation (e.g., fear of heights, fear of airplanes, fear of crowds). Onset of phobias does not usually occur until late teens or early adulthood.

Somatization Disorders. There are a number of childhood illnesses in which psychosocial factors are recognized as possible contributors to the onset and continuation of physical symptoms. Some of these illnesses include: dermatitis, juvenile rheumatoid arthritis, bronchial asthma, essential hypertension, rapid heart rate or rapid breathing, migraine, recurrent abdominal pain, peptic ulcer, and diabetes.

THE EDUCATIONAL RIGHTS OF YOUTH WITH EMOTIONAL DISABILITIES

THE EDUCATIONAL RIGHTS OF YOUTH WITH EMOTIONAL DISABILITIES

The educational system is second only in importance to family care givers in determining whether the youth with an emotional disability will live in a normal environment. The family aside, a youth spends more time in school than in any other setting. The youth with an emotional disability who is expelled from school is likely to end up back in the hospital. Therefore, maintaining the school placement must be a priority of the family advocate.

Often there is inadequate communication and coordination among parents, mental health providers, and school personnel regarding the youth with the emotional disability. Most of these individuals can make it in the public school system given appropriate services and adequate support. To help insure the youth receives the educational services to which he or she is entitled the case manager and family caregivers must be knowledgeable about the law in this area. Federal law mandates specific services to individuals with emotional disabilities. While state laws vary somewhat, a summary of Kansas law is included in this section as an example.* Case managers from other states should obtain copies of their state's laws from the department of education or advocacy groups.

Each person who is determined eligible for special education services will receive an Individualized Education Program (IEP) which specifies the services he or she will receive and who is to provide them. Since the IEP is an important part of the school experience for many youth with emotional disabilities information about it has been included in the appendix.**

*The material titled, "Education," originally appears in the pamphlet: *Legal Rights of and Services for Kansans with Disabilities*, 1986. It is published by and reprinted here with the permission of:

Kansas Advocacy and Protective Services
for the Developmentally Disabled, Inc.
Suite 2, Denholm Building
513 Leavenworth
Manhattan, KS 66502
(913) 776-1541 or
(Toll Free: 1-800-432-8276)

**The material titled, "Individualized Education Programs," is published by and reprinted here with the permission of:

National Information Center for Handicapped Children and Youth (NICHY)
P.O. Box 1492
Washington, D.C. 20013

Suggested resources

- ★ Statewide Lawyer Referral Service, Kansas Bar Association
- ★ Private attorney
- ★ Kansas Advocacy and Protective Services for the Developmentally Disabled, Inc.
- ★ Legal clinics, Kansas University and Washburn Law Schools
- ★ District Attorney

Chapter 7

Source: Legal Rights of and Services for Kansans with Disabilities. Kansas Advocacy and Protective Services for the Developmentally Disabled, Inc. 1986

Education

"It is doubtful that any child may reasonably be expected to succeed in life if he is denied the opportuniy of an education."

U. S. Supreme Court
Brown v. Board of Education
347 U.S. 483, 493

Introduction

For many years, education was regarded as important only for "normal" children. Children with mental, physical, emotional, or learning handicaps were excluded, suspended or otherwise denied a free public education. As recently as 1972, only 40 percent of the disabled children in this country were receiving an education.

In the early 1970's, two landmark court cases paved the way for many changes that have been made in educational systems for developmentally disabled children. The first case, *Pennsylvania Association for Retarded Citizens* v *Commonwealth of Pennsylvania*, involved mentally retarded children in Pennsylvania who were denied an "appropriate education." A three-judge federal court ruled, in 1971, that every mentally retarded person in Pennsylvania must be given "access to a free public education and training appropriate to his learning capacities." While this case included only mentally retarded persons, the second case, *Mills* v *Board of Education of the District of Columbia*, involved persons with other or additional handicapping conditions. The ruling in the Mills case required publicly supported education for all school age children who were residents of the District of Columbia, including those who were alleged to have mental, behavioral, physical, or emotional handicaps or deficiencies.

The Kansas Legislature passed The Special Education For Exceptional Children Act in 1974. This Act guarantees the state's exceptional (disabled and gifted) children the right to a free and appropriate educational opportunity.

In 1975, Congress passed Public Law 94-142 entitled "The Education For All Handicapped Children Act."

The purpose of this chapter is to describe some of the major concepts involved in the education of disabled children and to discuss some of the laws and regulations that attempt to assure that these

concepts become realized in the provision of educational services to children with disabilities.

Special Education Concepts

The foundation of state and federal laws and regulations pertaining to special education is based in several major concepts. Seven of the most important of these concepts are:

1) free and appropriate education;
2) comprehensive evaluation;
3) individualized education program (IEP);
4) least restrictive alternative;
5) due process (including due process hearings);
6) related services; and
7) confidentiality

Especially for some parents of special education students, involvement in the special education process can be an overwhelming and confusing experience. By becoming familiar with these and other related concepts, one is in a better position to understand the complexities of special education. With that in mind, the concepts listed above, as well as the laws and regulations through which they are expressed, will be discussed in some detail. Emphasis will be placed on special education procedures that are required in Kansas. These procedures are contained in Article 12 of the Kansas Administrative Regulations, in the State Plan for Special Education, and in Kansas law.

Free and appropriate education

In 1972, it was estimated that there were seven million children in the United States who had emotional, learning, mental or physical disabilities. At that time, only 2,800,000, or about 40 percent, of those children, were receiving an education.

This was of concern to many who were involved in working with persons with disabilities. As a result, lawsuits challenging the failure to educate disabled children were filed. In October, 1971, a federal court ordered that every mentally retarded person in Pennsylvania be given "access to a free public program of education and training appropriate to his learning ability."

This court ruling and others, many believe, played a part in the decision of Congress to pass Public Law 94-142 in 1975. PL 94-142 requires educational agencies to provide free educational oppor-

tunities for all children with handicaps and to provide an appropriate individualized educational program for each child. Kansas law contains a similar requirement.

So, the importance of the concept of "a free and appropriate education" grows out of the fact that each disabled student is entitled to one of them. Translating this requirement into reality, however, has not been without difficulty.

"Free education" means that educational and related services must be provided to the disabled student at no cost to him or her, or to his or her parents or guardian. Fees for such items as book rental or lunch charges, however, that are imposed on nondisabled students may also be required of disabled students.

The term "appropriate, education" has been more difficult to define. In 1982, the United States Supreme Court issued a ruling in *Hendrick Hudson School District* v. *Rowley*. In the *Rowley* case, which involved the issue of whether an interpreter must be provided to a hearing impaired child in a regular classroom, the Court outlined its views on the nature of an appropriate education.

After describing the requirements of PL 94-142, the Court stated, "a 'free appropriate public education' consists of educational instructions specially designed to meet the unique needs of the handicapped child, supported by such services as are necessary to permit the child 'to benefit' from the instruction."

In summarizing its decision the court used essentially the same language. "Insofar as the State is required to provide a handicapped child with a 'free appropriate education, we hold that it satisfies this requirement by providing personalized instruction with sufficient support services to permit the child to benefit educationally from that instruction."

Applying this decision is not easy. For example, some school districts have interpreted the decision to mean that they are not required to provide an "ideal" program for each disabled child.

From a disabled student's point of view, one of the more significant elements of the Court's ruling is the requirement that the student must receive an educational benefit from the program provided to him or her. The notion of what constitutes a "benefit" can be approached in various ways, one of which involves the extent to which the student is making educational progress. It is questionable whether a student can be benefiting from a program if he or she is not making progress. An appropriate education, then, can be thought of as one that enables a disabled student to make clear and definite progress toward educational goals that are consistent with the student's ability. If such progress is not evident, the student's educational program is, at least in part, apparently inappropriate.

Definitions

Kansas law contains two important definitions. One describes the disabled students to whom a free and appropriate education must be provided, and the other establishes the time span during which such an education must be available.

In Kansas, exceptional children are defined as those who "differ in physical, mental, social, emotional or educational characteristics to the extent that special educational services are necessary to enable them to progress toward the maximum of their abilities or capabilities." This definition includes those children who are mentally retarded, hearing impaired, language impaired, speech impaired, behavior disordered, physically impaired, health impaired, visually impaired, severely multiple handicapped/deaf blind or who have learning disabilities. Gifted children are also included within the definition.

For exceptional children, school age means "from the age at which the local board of education provides educational services for non-exceptional children, to and including the school years in which the exceptional child reaches age 21 or completes a local curriculum, in accordance with State board standards, whichever event occurs first."

A bill enacted by the Kansas Legislature in 1986 may lengthen the period of time during which educational services are provided to disabled students. The bill applies to districts in which four-year-old exceptional children receive special education services. Additional state aid to education funding will be provided to those districts.

Comprehensive evaluation

The comprehensive evaluation is a crucial element of the special education process. It is important at two levels. First of all, the results of a comprehensive evaluation are considered in deciding if a student is eligible to receive special education services. Secondly, assuming the student qualifies for services, information gained during the comprehensive evaluation is used in the development of an appropriate educational program.

There are, however, other steps that normally occur prior to the administration of a comprehensive evaluation. The local education agency, which may be a school district or a special education cooperative, has other specific responsibilities that must be carried out to assist in the identification of students who may have special needs.

Pre-School screening

Every local education agency is required to offer and publicize preschool screening activities. This is for children who are not yet old enough for school. The purpose of the screening is ordinarily to identify children with suspected developmental problems. At a minimum, the screening services are to be made available once each year. The screening is to include the following:

1) A hearing screening,
2) A vision screening, and
3) A developmental screening, including the areas of:
   a) communications;
   b) gross and fine motor skills;
   c) cognition;
   d) social and emotional adjustment; and
   e) self help skills

Although the preschool screening is to be made available, parents are not required to have their child screened.

Screening/diagnosis

Once a child reaches school age, another step takes place. Each local education agency must have systematic and on-going procedures through which all school age children are screened. This is done in order to discover those who may need special education services. This screening is the first step in the identification of exceptional children. It must include:

1) a mandatory hearing and vision screening;
2) an age appropriate procedure designed to identify possible physical, intellectual, social, emotional, language or perceptual deviations; and
3) any other necessary supplementary instruments or procedures.

After the screening is completed, appropriate follow-up should be initiated. If there are indications from a child's performance that he/she may have a disabling condition, the child is to be referred for preassessment.

Preassessment

Under Kansas regulations, no child who is enrolled in regular education may be identified as being exceptional unless a multidisciplinary team has documented:

1) that the child has been presented with learning experiences which are appropriate for the child's age and ability levels; and
2) that the child's potential for learning has not been achieved in the regular education environment.

This procedure is intended for all students who demonstrate significant learning and/or behavior differences, and it is the first phase in determining whether the educational needs of a student can be met within the regular classroom.

Evaluations

In Kansas, no child may be placed in special education prior to the completion of a comprehensive evaluation. The evaluation may be requested by the child's parents, or the school may refer the child for an evaluation.

When the school refers the child for an evaluation, a written notice that this is recommended must be made to the parents (or the guardian), and their written consent is to be requested. If the parents refuse to consent, the school district should try to reach a resolution by conferring with the parents. If the disagreement is not resolved, the school district has certain options available. Among them are to accept the parent's decision, or to initiate a due process hearing.

On the other hand, if the parents request an evaluation, and the school denies the request, the parents may initiate a due process hearing. The purpose of the hearing would be to determine whether a comprehensive evaluation should be administered to the student.

If an evaluation is made by the school, and if the parents disagree with the procedures or results of that evaluation, they have the right to an independent evaluation. This independent evaluation must be made available at public expense if the parents can show that the school's evaluation was inappropriate. If the parents cannot show that the evaluation was inappropriate, then they must pay for the independent evaluation. In either case, the school must consider the results of the independent evaluation when making decisions about the education of the child.

Kansas regulations and the State Plan specify several requirements for comprehensive evaluations. Among them are

1) The evaluation is to be non-discriminatory in that
   a) If a child is from a home in which English is not the primary language spoken, the school must determine the language best understood by the child; and
   b) If the child has sensory, motor or speaking impairments, tests or procedures used should take into

account rather than reflect the child's impaired communication skills

2) The evaluation must be multidisciplinary. A team of qualified professionals should administer the evaluation.
3) The evaluation must be multisourced. In no instance is a child to be placed in special education on the basis of a single procedure, instrument or measure.
4) All areas related to a child's suspected disability must be assessed during the evaluation.
5) All tests or other evaluation material administered during the evaluation must be validated for and appropriate for the purpose for which they were used.
6) During the course of the evaluation, the following factors must be considered:
   a) The child's developmental, psychological, social and educational functioning;
   b) His/her physical health or sensory impairment which may influence learning; and
   c) The classroom and school learning climate.
7) The comprehensive evaluation is to be completed as soon as possible following the referral.
8) After completion of the comprehensive evaluation, the multidisciplinary team should meet to determine whether the evaluation results indicate that the child needs special education services. The child's parents must have the opportunity to attend this meeting, or have their views expressed during the meeting.
9) In no case is the decision to place a child in special education to be made by one person.
10) If an evaluation team recommends a child for special education services, the evaluation results are to be made available for use in developing the student's individualized education program.

Re-evaluation

According to Kansas regulations and the State Plan, a comprehensive re-evaluation is to be made any time conditions warrant such a re-evaluation, or if the child's parent or teacher requests a new evaluation. At a minimum, though, a student receiving special education services must be re-evaluated every three years.

Although parents must be notified, in writing, about the three year evaluation, in some cases, consent is not required. This is if the child's initial placement was made properly within the applicable

regulations, and if his/her program is current and has been reviewed or revised annually.

In any case, comprehensive re-evaluations must comply with the requirements for initial evaluations that were outlined above.

Individualized education program (IEP)

If the results of a comprehensive evaluation indicate that a child is in need of special education services, an IEP is developed for that child. The IEP is a very important document. It is a written statement of the special education and related services needed by a child. The IEP assigns responsibility for delivery of the services to be provided. It also describes anticipated changes in the child and outlines how these changes will be measured.

Participants in the development of the IEP

The IEP is prepared by a team, in a team meeting. At a minimum, the following persons should participate in the meeting during which the IEP is developed.

1) The child's teacher or teachers, both regular education, if appropriate, and special education;
2) Another representative of the local education agency, one who can authorize the provision of special education services;
3) One or both parents or a guardian;
4) The child, if appropriate; and
5) Other persons who the parents or the school may invite to attend.

There are a number of other persons whose attendance at IEP meetings may be appropriate. For example, therapists or other professionals who work with the child would have important contributions to make. Parents might want to invite someone who is knowledgeable about special education to attend the meeting with them. Parents who are uncomfortable with such meetings could consider inviting another relative or a close friend. The support provided by such persons is often helpful.

If an educational advocate has been appointed for a child, that person should also attend IEP meetings. An educational advocate is appointed for any child who is in the custody of the Secretary of the Department of Social and Rehabilitation Services, and who is known or suspected to be an exceptional child, if:

1) the parental rights of the parents of the child have been terminated; or
2) the child's lawful custodian is unknown or unavailable.

The educational advocate is responsible for protecting the child's rights in the education and decision-making process. An educational advocate may also exercise any other rights given by law to the parents of special education students.

The parents of a special education student should be notified of an IEP meeting early enough to insure that they will be able to attend and participate in the meeting. The notice should be in writing. It is the responsibility of the school to make a reasonable attempt to schedule the IEP meeting at a mutually agreed upon time and place. If the parents are unable to attend the meeting, other methods of gaining their participation, such as conference calls, are permissable.

According to the State Plan, no child is to be placed in a special education program prior to the development of an IEP. In certain limited situations, for a brief period of time not to exceed 30 days, children may begin to receive services before a complete IEP is finalized. This might be done when additional information is necessary in order to develop the most appropriate program for the child, or when a student is new to a district. In such an instance, an "interim IEP" is prepared. By the conclusion of the time during which the interim IEP was in effect, a complete IEP must have been developed for the student.

Required elements of a written IEP

The intent of the law describing the content of a written IEP is to insure that appropriate and individualized programming is provided to each special education student. To accomplish that end, the State Plan requires each IEP to include the following:

1. A statement of the child's present level of educational performance, including, where applicable, academic achievement, social adaptation, prevocational skills, sensory and motor skills, self-help skills, and speech and language skills.
2. A statement of annual goals which describe the educational performance anticipated within a year's time.
3. A statement of short-term objectives which are measurable, intermediate steps between the present level of performance and the annual goals.
4. Objective criteria, evaluation procedures, and data collection

schedules for determining, at least every twelve weeks, whether the short-term objectives are being achieved.

5. A statement of the specific special education and related services needed by the child without regard to the availability of such services. Any unique instructional media not ordinarily available to all students, but needed by the child for learning, shall be listed. For example, large print materials, braillers, amplification equipment, and non-oral communication devices should be listed.
6. A description of the extent to which the child will participate in regular education. Where regular classroom placement is not appropriate, the extent of participation in other less restrictive environment activities shall be described.
7. The projected date for the initiation of the prescribed services and anticipated duration of the services.
8. A listing of the names and positions of the individuals responsible for implementation of the individualized education program.

Ideally, parents and school representatives should work together in developing the IEP. It is not a technical requirement, though, that a parental signature must be placed on the IEP before the child's program is implemented. Parents may consent to a special education identification and placement for a child, but still not agree with the program provided to the child.

In any event, a copy of the IEP must be provided to the parents of the child for whom it was developed. Additionally, each IEP must be revised or reviewed annually.

Additional issues

Questions about other important issues sometimes arise in connection with discussions of a disabled student's IEP. Among those issues are:

1) Extended year programs — Some disabled children lose the skills they learn easily, and then have difficulty relearning those skills. Such students might well be eligible for extended year program. Each student's need for such a program must be assessed on an individual basis. The child's IEP should reflect a decision to provide extended year or summer school services. Local education agencies may not impose a total prohibition on summer school or an extended school year.

2) Suspension and expulsion — Some courts have ruled that expulsion or repeated short term suspension of special education students amounts to a denial of a free and appropriate education to those students and therefore is improper. This has happened when there is a relationship between the student's conduct and his/her disability. These students may not, however, violate or disregard school rules. Alternative disciplinary actions may be used. If the alternatives fail, the IEP team meets to determine whether the student's current placement is appropriate. During such a meeting, alternative placements may also be considered.
3) Transitional plans — In 1986, the Kansas Legislature authorized the Secretary of the Department of Social and Rehabilitation Services to develop transitional plans for certain special education students. The transitional planning, which is conditioned on the availability of funding and staffing, could begin as early as two years before a student completes his/her special education program.

Least restrictive environment

As it is explained in the Kansas State Plan for Special Education, the least restrictive environment principle establishes the right of an exceptional child to have an opportunity for an appropriate education with nonexceptional students to the maximum extent possible. To be in a restrictive setting effectively means that some students will not have an opportunity to be with and to interact with children of the same age group, in the same facilities and in the same social situations.

Because of the different kinds of disabilities and the different degrees of disabling conditions, some exceptional children, it is believed, do not learn well in "regular" educational settings. With this in mind, Kansas schools have been required to develop a continuum of educational environments. From the least restrictive to very restrictive environments, this continuum is as follows:

1. placement in the regular classroom;
2. placement in the regular classroom with special instructional materials or equipment;
3. placement in the regular classroom with a consulting teacher;
4. placement in the regular classroom with an itinerant teacher plan;
5. placement in a regular classroom with attendance in a

resource room, for part of the time only, that has special equipment and a special teacher;

6. placement in an integrated special classroom program most of the time and only sometimes participating in regular classes;
7. placement in segregated day schools that have specialized classes, modified facilities, and special services for exceptional learners;
8. placement in separate residential schools;
9. provision for individual or group instruction to those students who are confined to hospitals or convalescent homes for either medical or psychiatric treatment;
10. provision for instruction to those whose health problems are so severe that school attendance is impossible or to those persons who are temporarily disabled.

The State Plan also requires that special education is to be provided as close as possible to the child's home. The assumption is that the student should attend the school to which he/she would go in the absence of a disability, unless the student's IEP calls for a special education program available only in an alternative setting.

The decision about the type of placement to which a child is assigned is made by the child's IEP team. The IEP process is used, then, to bring about movement of children to less restrictive settings, and also to insure that disabled children will be in contact with non-disabled students. No placement is considered permanent, but rather is always subject to review. At any point, a decision can be made to move a student to a less restrictive setting. In theory, the goal for all students is to place them in progressively less restrictive educational environments.

The practice of placing special education students in segregated facilities, or buildings just for disabled students, is not uncommon in Kansas. Questions sometimes arise about whether this violates the least restrictive environment principle. The view of the Special Education Administration Office within the Kansas State Department of Education on this issue is as follows:

> In the opinion of this office, "least restrictive environment" is not a place; rather it is a principle which says that to the fullest extent possible handicapped children will be educated with nonhandicapped peers. There is no law which forbids a facility which houses only handicapped students. Violations of the least restrictive environment concept occur when placement in such a special education school is the *sole educational option* (em-

phasis in the original) available to all children in a given category of exceptionality. Each handicapped student must be placed in the program that best meets his/her individual needs. That program may be delivered totally or in part in a facility which houses only handicapped students. Opportunities for interaction with less handicapped or normal students also should be planned on an individual basis. These opportunities can be provided in a variety of ways. . . .

Due Process

The State Plan speaks of "due process requirements", "due process procedures", "due process hearing", and simply "due process". These phrases indicate that there be certain steps and actions that are required of the school or of the parents in order to get appropriate services provided for the child. These phrases also indicate that there are certain steps and actions required of the school and of the parents in order to settle differences about special education programs or services.

The terms "notice" and "consent" often arise in connection with the consideration of due process issues. These terms are very important. First of all, there are certain notices that are required as a matter of due process. For example, a written notice must be provided to a child's parents before the child is "excluded, reassigned or transferred" from a regular education placement on the basis that he/she is an exceptional child. A written notice is also necessary before a child is "placed in, transferred to or from, or denied placement in special education services offered an exceptional child" is made.

A notice requirement is often accompanied by an additional requirement that parents of a special education student must consent to an action proposed by the school. Such consent is required before a school can finalize any of the actions mentioned in the previous paragraph. Failure to consent, however, can sometimes cause the school to initiate due process proceedings.

Due process hearing

Sometimes differences between parents and the school about the appropriateness of some special education action seem impossible to resolve by informal procedures. After efforts to settle the differences have failed, either the parents or the local education agency may initiate a "due process hearing". The parents do this by requesting a hearing in a letter to the Board of the local education agency. The State Plan provides specific requirements for the hearing and it carefully outlines the procedure in detail. One important requirement is that the

hearing is to be at no cost to the parents of the disabled child.

The selection of a hearing officer can be a crucial part of the hearing. The process begins when the local education agency (either a school district or special education cooperative) provides to the parents its list of prospective hearing officers. This procedure is followed without regard to whether the school or the parents asked for the hearing.

The parents have the right to disqualify all of the persons on the school's list. If that is done, the State Board of Education submits to both the school and the parents a list of five additional prospective hearing officers and the qualifications of those individuals. Both of the parties then have the option of removing one or two of the names from the State Board's list. Eventually, then, the State Board of Education appoints as the hearing officer someone whose name was not removed from its list. Once the hearing officer is appointed, he or she has the responsibility of "assuring that due process is afforded both parties to the hearing".

The State Plan requires that prior to the hearing, the hearing officer must:

1. Verify through personal or telephone contact that the parents understand their right to an independent evaluation and their right of access to school reports, files, and records related to the proposed action.
2. Verify through personal or telephone contact that both parents and school officials understand the rights of parties in a due process hearing. These rights, as specified in K.S.A. 72-973 are:

   a. The right of the parties to have counsel of their own choice present and to receive the advice of such counsel or other person whom they may select;
   b. The right of the lawful custodian of the child to be present at the hearing;
   c. The right of the child, the lawful custodian of the child and their counsel or advisor to hear or read a full report of the testimony of witnesses responsible for recommending the proposed action and of any other material witnesses;
   d. The right of the parties and their counsel or advisor to confront and cross-examine witnesses who appear in person at the hearing, either voluntarily or as a result of the issuance of a subpoena;

e. The rights of the parties to present witnesses in person or their testimony by affidavit, including expert medical, psychological, or educational testimony;
f. The right of the child to testify in his or her own behalf and give reasons in opposition to the proposed action;
g. The right of the parties to prohibit the presentation of any evidence at the hearing which has not been disclosed to the opposite party at least five (5) days prior to the hearing;
h. The right of the parties to have an orderly hearing;
i. The right of the child to a fair and impartial decision based on substantial evidence; and
j. The right of the parties to have a record of the hearing made by mechanical or electronic recording or by an official court reporter.

3. Make arrangements for an interpreter if necessary. At all stages of the due process procedures, interpreters for deaf and non-English speaking parents/children must be provided at the expense of the school district
4. At least ten days before the hearing, notify each party, in writing, of the right of the parties to prohibit presentation of evidence which has not been disclosed to the opposite party at least five days prior to the hearing.
5. At least five days before the hearing, notify the parents, in writing, of the time and place of the hearing. This is to be at a time and a place reasonably convenient to the parents.
6. If necessary, request the clerk of the district court to issue subpoenas for the attendance of witnesses and/or the production of relevant records.
7. Determine parent/child wishes regarding the participation of the child in the hearing. If the child is over the age of majority, he/she has the right to attend the hearing. If the child has not reached the age of majority, the parents have the right to determine whether he/she should attend the hearing, unless the hearing officer finds that attendance by the child would be harmful to his/her welfare. The child may then be excluded from portions of or the entirety of the hearing by the hearing officer.
8. Determine parental wishes as to whether the hearing will be open or closed. The hearing is closed to the public unless the parents request an open hearing.

No later than five days before the hearing, each party must be

furnished with a hearing agenda. This is to include a written summary of the evidence to be submitted at the hearing, and a list of the witnesses each party intends to call during the hearing. This responsibility may be carried out at a prehearing conference. The issues to be resolved during the hearing are normally clarified during the prehearing conference, and if a lack of communications between the home and school is the basic problem, such a conference may provide a useful way of resolving the disagreement.

The hearing officer presides at the actual hearing, which is to be conducted "in a fair and impartial manner". Each party must have the opportunity to present their evidence and testimony. The burden of proof as to the appropriateness of any of its actions is to be on the local education agency.

The hearing officer is required to make a written decision on the issues in the hearing not more than ten days after the conclusion of the hearing. The hearing officer's decision is final, subject to the right of either party to appeal that decision.

The initial appeal, if it is made, is to the State Board of Education. This appeal is accomplished by filing a written notice of appeal with the State Commissioner of Education. The notice must be filed no later than ten days after receipt of the hearing officer's written decision. Subsequently, a reviewing officer, appointed by the State Board, will conduct a review of the case. This review may include an additional hearing. If either party disagrees with the decision of the reviewing officer, an additional appeal can be made to the district court.

The United States Congress, in 1986, enacted legislation that may benefit parents of children with disabilities who are involved in due process hearings or subsequent appeals. This law, in general, provides that the parents or guardians of a disabled child may recover attorney's fees and related costs if they prevail in special education due process hearings, or judicial proceedings resulting from such hearings.

Alternatives to due process

Because of the demands a due process hearing places on both the school and a child's family, such a hearing might reasonably be viewed as a last resort alternative. The times that parents and school personnel are required to meet can be used by the school to discover parental concerns and to improve communication. Enhanced communication may contribute to the resolution of disagreements between schools and families.

The State Plan encourages school districts to utilize the following procedures to prevent disagreements which require resolution through a due process hearing:

1) In service for administrators, teachers and support staff on communication skills and conferring with parents of exceptional children.
2) Public dissemination of information on local special education services and parent/child rights.
3) Informal mediation or conflict resolution procedures to precede any scheduled due process hearing or formal prehearing activity.
4) Meetings or workshops for parents and other persons in the community.

Noncompliance complaints

According to the State Plan, a formal complaint of procedural noncompliance can be made to the Kansas State Department of Education "when a person or organization believes that a local education agency's . . . policies, practices or procedures violate State or federal laws or regulations". The Plan goes on to explain that, to be the subject of such a complaint, the violations of laws or regulations occur on a system-wide basis, as opposed to involving a single child or incident.

This policy appears, however, to contradict an interpretation issued by a federal agency responsible for monitoring the implementation of PL 94-142. The federal view is that any alleged violation of laws or regulations can be investigated in response to a complaint of noncompliance. This would be true even if the violation involved only one special education student. After all, it seems unreasonable to expect parents of exceptional children to be responsible for compelling school districts to comply with applicable laws and regulations.

Related Services

The importance of related services results from the fact that, in some cases, such services will be an essential element of a disabled student's free appropriate education. Related services are those services that are required to assist an exceptional child to benefit from special education. The State Plan lists the following related services that could be included, if appropriate, in a disabled student's IEP: "art therapy, audiology, counseling services, dance movement therapy, medical services for diagnostic or evaluation purposes, music therapy, occupational therapy, parent counseling and training, physical therapy, school psychological services, recreation, school health services, school social work services, special music education, speech or language services, and transportation". Not all of the services will be necessry for each disabled student.

Disagreements have arisen about whether a particular service falls within the definition of related services. Reference to a ruling issued by the United States Supreme Court in 1984 provides some guidelines for resolution of such disagreements. *Irving Independent School District* v. *Tatro* involved a girl with spina bifida who required a procedure called clean intermittent catheterization (CIC) every three to four hours. The school, however, was reluctant to provide this service.

The parents appealed through the legal system, and eventally, the case was brought before the Supreme Court. The Court concluded that the girl could not attend school and benefit from special education without CIC services being available. Therefore, the services might properly be considered a related service. The Court added that such services "were no less related to the effort to educate than are services that enable the child to reach, enter or exit the school". The exclusion of "medical services" did not apply because CIC services are not provided by a physician. Rather, a nurse or other qualified person could provide the service. The point of this description of the *Tatro* case is to illustrate that the range of services that may be considered to be related services appears to be rather broad. If a disabled child requires a particular service in order to remain in school, in all likelihood, that service can be provided for and listed on his/her IEP.

In Kansas, "psychotherapy is considered medical in nature, and its provision shall not be a responsibility of the public schools". Legal decisions, though, in other states, have held to the contrary. In some cases, the courts have decided, psychotherapy can be a required related service. Kansas regulations also provide that, "School districts shall not be responsible for psychological, psychiatric or social services required to treat generalized mental health problems".

Under certain circumstances, a related service, itself, may be recognized and treated as special education. This means that the child receiving the service does not have to be identified as falling into one of the categories of exceptional children. This applies only to the following services:

(1) Occupational therapy, physical therapy, paraprofessionals, or transportation when needed to maintain students in regular education; and

(2) Interpreters for any deaf child who, without this service, would have to be educated in a more restrictive environment.

Also, in order to receive these services, the child's IEP must indicate that he or she cannot function in regular education without the service or services.

Related services are normally delivered directly to a student, but sometimes can be provided on a consultative basis to a teacher or parent. Qualified professionals must deliver related services, but not infrequently the service is provided by a person who is supervised by a qualified professional.

Confidentiality

Confidentiality is the last of the important special education concepts listed at the beginning of the chapter. Following the precedent of federal legislation, Kansas law requires the State Board of Education and the board of every school district to adopt a policy "to protect the right of privacy of any student or pupil and his or her family regarding personally identifiable records, files, and data directly related to such student or pupil".

In carrying out this requirement, the State Plan outlines specific procedures in the following areas:

1) Access rights of parents — Parents or their representative are to be allowed to inspect any personally identifiable information relating to their child without unnecessary delay (within 45 days after a request is made).
2) Right to amend records — Parents may request appropriate amendments to records which they believe to be inaccurate, misleading, or in violation of the privacy or other rights of the child. If the records are not amended within a reasonable period of time, the parents may request a hearing to determine whether the amendments should be made.
3) Requirement of parental consent — With the exception of certain very limited situations, no personally identifiable information about a student may be released without the consent of the student's parents.

The State Plan also specifies that when personally identifiable information is no longer needed in order to provide educational services to a child, the child's parents should be contacted. At that time, the parents must be notified that the information, other than essential academic records, may, upon request, be destroyed.

Additional information about the concept of confidentiality as it relates to persons with disabilities is provided in Chapter 8, the next chapter in this book.

Sample Letters
(Keep a copy for yourself.)

(To request an evaluation)

Route 1
Midway, Ks. 66000

July 5, 1986

Mr. Samuel Jones, Principal
USD #123
Midway, Ks. 66000

Dear Mr. Jones:

We believe our child, Sam, Jr., needs a special education program in order to reach his maximum potential. He was born on Oct. 15, 1975.

We will appreciate your scheduling him for an evaluation as soon as possible.

Sincerely,

Jane and Sam Graves

cc: B. J. Brown, Director of Special Education

(To request a hearing)

432 Black Avenue
Whitestone, Ks. 67000
July 10, 1986

Mr. A. W. Smith,Chairman
USD #321 Board of Education
Whitestone, Ks. 67000

Dear Mr. Smith:

We believe that the school is wrong in refusing to provide physical therapy for our daughter, Susan, and request a hearing on the matter.

Please contact us regarding the designation of a qualified, impartial hearing officer.

Sincerely,

A. B. Gramah

cc: A. A. Black, Superintendent
B. J. Brown, Director of Special Education

Conclusion

Recent laws and regulations, both Federal and State, have sought to create an education system that will enable the exceptional children of Kansas to "progress toward the maximum of their abilities or capacities". Each disabled child, however, needs parents, or guardians, school officials, and other advocates who will learn what is guaranteed by the laws and the regulations and who will actually monitor what takes place. Appropriate education will require cooperative effort by all who are concerned that the exceptional child can and will enjoy success in life.

Suggested Resources

- ★ Special Education Administration of Kansas Department of Education
- ★ Local Directors of Special Education
- ★ Kansas Advocacy and Protective Services for the Developmentally Disabled, Inc.

NICHCY
NATIONAL INFORMATION CENTER FOR HANDICAPPED CHILDREN AND YOUTH
P.O. BOX 1492 · WASHINGTON, D.C. 20013

§300.340 Definition.

Individualized Education Programs

As used in this part, the term "individualized education program" means a written statement for a handicapped child that is developed and implemented in accordance with §§300.341-300.349. *(20 U.S.C. 1401(19).)*

Interpretation of Requirements Under Part B of the Education of the Handicapped Act, As Amended by Pub. L. 94-142

I. Purpose of the IEP

There are two main parts of the IEP requirement, as described in the Act and regulations: (1) The IEP meeting(s), at which parents and school personnel jointly make decisions about a handicapped child's educational program, and (2) the IEP document itself, which is a written record of the decisions reached at the meeting. The overall IEP requirement, comprised of these two parts, has a number of purposes and functions:

a. The IEP meeting serves as a communication vehicle between parents and school personnel, and enables them, as equal participants, to jointly decide what the child's needs are, what services will be provided to meet those needs, and what the anticipated outcomes may be.

b. The IEP process provides an opportunity for resolving any differences between the parents and the agency concerning a handicapped child's special education needs; first, through the IEP meeting, and second, if necessary, through the procedural protections that are available to the parents.

c. The IEP sets forth in writing a commitment of resources necessary to enable a handicapped child to receive needed special education and related services.

d. The IEP is a management tool that is used to ensure that each handicapped child is provided special education and related services appropriate to the child's special learning needs.

e. The IEP is a compliance monitoring document which may be used by authorized monitoring personnel from each governmental level to determine whether a handicapped child is actually receiving the free appropriate public education agreed to by the parents and the school.

f. The IEP serves as an evaluation device for use in determining the extent of the child's progress toward meeting the projected outcomes.

Note.—The Act does not require that teachers or other school personnel be held accountable if a handicapped child does not achieve the goals and objectives set forth in the IEP. See §300.349, *Individualized education program—accountability.*

II. IEP Requirements

This part (1) repeats the IEP requirements in §§300.340-300.349 of the regulations (boxed material), (2) provides additional clarification, as necessary, on sections or paragraphs of the regulations on which such clarification is needed, and (3) answers some questions regarding implementation of the IEP requirements that are not expressly addressed in the regulations. These questions and clarifying information are presented in a question and answer format immediately after the particular section of the regulations that is presented.

§300.341

State educational agency responsibility

(a) *Public agencies.* The State educational agency shall insure that each public agency develops and implements an individualized education program for each of its handicapped children.

(b) *Private schools and facilities.* The State educational agency shall insure that an individualized education program is developed and implemented for each handicapped child who:

(1) Is placed in or referred to a private school or facility by a public agency; or

(2) Is enrolled in a parochial or other private school and receives special education or related services from a public agency.

(20 U.S.C. 1412 (4), (6); 1413(a)(4).)

Comment: This section applies to all public agencies, including other State agencies (e.g., departments mental health and welfare), which provide special education to a handicapped child either directly, by contract or through other arrangements. Thus, if a State welfare agency contracts with a private school or facility to provide special education to a handicapped child, that agency would be responsible for insuring that an individualized education program is developed for the child.

---

1. *Who is responsible for ensuring the development of IEPs for handicapped children served by a public agency other than an LEA?*

The answer will vary from State to State, depending upon State law, policy, or practice. In each State, however, the SEA is ultimately responsible for ensuring that each agency in the State is in compliance with the IEP requirements and the other provisions of the Act and regulations. (See §300.600 regarding SEA responsibility for all education programs.)

The SEA must ensure that every handicapped child in the State has available a free appropriate public education (FAPE), regardless of which agency, State or local, is responsible for the child. While the SEA has flexibility in deciding the best means to meet this obligation (e.g., through interagency agreements), there can be no failure to provide FAPE due to jurisdictional disputes among agencies.

Note.—Section 300.2(b) states that the requirements of the Act and regulations apply to all political subdivisions of the State that are involved in the education of handicapped children, including (1) the SEA, (2) LEAs, (3) other State agencies (such as Departments of Mental Health and Welfare, and State schools for the deaf or blind), and (4) State correctional facilities.

The following paragraphs outline (1) some of the SEA's responsibilities for developing policies or agreements under a variety of interagency situations, and (2) some of the responsibilities of an LEA when it initiates the placement of a handicapped child in a school or program operated by another State agency.

a. SEA POLICIES OR INTERAGENCY AGREEMENTS. The SEA, through its written policies or agreements, must ensure that IEPs are properly written and implemented for all handicapped children in the State. This applies to each interagency situation that exists in the State, including any of the following: (1) When an LEA initiates the placement of a child in a school or program operated by another State agency (see "LEA-Initiated Placements" in paragraph "b", below); (2) when a State or local agency other than the SEA or LEA places a child in a residential facility or other program; (3) when parents initiate placements in public institutions; and (4) when the courts make placements in correctional facilities.

Note.—This is not an exhaustive list. The SEA's policies must cover any other interagency situation that is applicable in the State, including placements that are made for both educational and for non-educational purposes.

Frequently, more than one agency is involved in developing or implementing a handicapped child's IEP (e.g., when the LEA remains responsible for the child, even though another public agency provides the special education and related services, or when there are shared cost arrangements). It is important that SEA policies or agreements define the role of each agency involved in the situations described above, in order to resolve any jurisdictional problems that could delay the provision of a free appropriate public education to a handicapped child. For example, if a child is placed in a residential facility, any one or all of the following agencies might be involved in the development and or implementation of the child's IEP: The child's LEA, the SEA, another State agency, an institution or school under that agency, and the LEA where the institution is located.

Note.—The SEA must also ensure that any agency involved in the education of a handicapped child is in compliance with the "least restrictive environment" provisions of the Act and regulations, and, specifically, with the requirement that each handicapped child's placement (1) be determined at least annually, (2) be based on the child's IEP, and (3) be as close as possible to the child's home (§300.552(a), *Placements*.)

b. LEA-INITIATED PLACEMENTS. When an LEA is responsible for the education of a handicapped child, the LEA is also responsible for developing the child's IEP. The LEA has this responsibility even if development of the IEP results in placement in a State-operated school or program.

Note.—The IEP must be developed before the child is placed. (See Question 5, below.) When placement in a State-operated school is necessary, the affected State agency or agencies must be involved by the LEA in the development of the IEP. (See response to Question 39, below, regarding participation of a private school representative at the IEP meeting.)

After the child enters the State school, meetings to review or revise the child's IEP could be conducted by either the LEA or the State school, depending upon State law, policy, or practice. However, both agencies should be involved in any decisions made about the child's IEP (either by attending the IEP meetings, or through correspondence or telephone calls). There must be a clear decision, based on State law, as to whether responsibility for the child's education is transferred to the State school or re-

mains with the LEA, since this decision determines which agency is responsible for reviewing or revising the child's IEP.

2. *For a child placed out of State by a public agency, is the placing or receiving State responsible for the child's IEP?*

The "placing" State is responsible for developing the child's IEP and ensuring that it is implemented. The determination of the specific agency in the placing State that is responsible for the child's IEP would be based on State law, policy, or practice. However, as indicated in Question 1, above, the SEA in the placing State is responsible for ensuring that the child has available a free appropriate public education.

Note.—The Department is considering the possibility of publishing a separate document on out-of-State placements. That paper would address the responsibilities of the placing and receiving States under both EHA-B and Section 504 of the Rehabilitation Act of 1973.

---

§ 300.342

When individualized education programs must be in effect.

(a) On October 1, 1977, and at the beginning of each school year thereafter, each public agency shall have in effect an individualized education program for every handicapped child who is receiving special education from that agency.

(b) An individualized education program must:

(1) Be in effect before special education and related services are provided to a child; and

(2) Be implemented as soon as possible following the meetings under § 300.343.

(20 U.S.C. 1412 (2) (B), (4), (6); 1414(a) (5); Pub. L. 94-142, Sec. 8(c) (1975).)

Comment. Under paragraph (b)(2), it is expected that a handicapped child's individualized education program (IEP) will be implemented immediately following the meetings under § 300.343. An exception to this would be (1) when the meetings occur during the summer or a vacation period, or (2) where there are circumstances which require a short delay (e.g., working out transportation arrangements). However, there can be no undue delay in providing special education and related services to the child.

---

3. *In requiring that an IEP be in effect before special education and related services are provided, what does "be in effect" mean?*

As used in the regulations, the term "be in effect" means that the IEP (1) has been developed properly (i.e., at a meeting(s) involving all of the participants specified in the Act (parent, teacher, agency representative, and, where appropriate, the child)); (2) is regarded by both the parents and agency as appropriate in terms of the child's needs, specified goals and objectives, and the services to be provided; and (3) will be implemented as written.

4. *How much of a delay is permissible between the time a handicapped child's IEP is finalized and when special education is provided?*

In general, no delay is permissible. It is expected that the special education and related services set out in a child's IEP will be provided by the agency beginning immediatley after the IEP is finalized. The comment following Section 300.342 identifies some exceptions ((1) when the meetings occur during the summer or other vacation period, or (2) when there are circumstances which require a short delay, such as working out transportation arrangements). However, unless otherwise specified in the IEP, the IEP services must be provided as soon as possible following the meeting.

Note.—§300.346(d) requires that the IEP include the "projected dates for initiation of services."

5. *For a handicapped child receiving special education for the first time, when must an IEP be developed—before placement or after placement?*

An IEP must "be in effect *before* special education and related services are provided to a child." (§ 300.342(b)(1), emphasis added.) The appropriate placement for a given handicapped child cannot be determined until after decisions have been made about what the child's needs are and what will be provided. Since these decisions are made at the IEP meeting, it would not be permissible to first place the child and then develop the IEP. Therefore, the IEP must be developed before placement.

The above requirement does not preclude temporarily placing an eligible handicapped child in a program as part of the evaluation process—before the IEP is finalized—to aid in determining the most appropriate placement for the child. It is essential that the temporary placement not become the final placement before the IEP is finalized. In order to ensure that this does not happen, the State might consider requiring LEAs to take the following actions:

a. Develop an "interim" IEP for the child, which sets out the specific conditions and timeliness for the trial placement. (See paragraph "c", below.)

b. Ensure that the parents agree to the interim placement before it is carried out, and that they are involved throughout the process of developing, reviewing, and revising the child's IEP.

c. Set a specific timeline (e.g., 30 days) for completing the evaluation and making judgments about the most appropriate placement for the child.

d. Conduct an IEP meeting at the end of the trial period in order to finalize the child's IEP.

Note.—Once a handicapped child's IEP is in effect and the child is placed in a special education program, the teacher might develop detailed lesson plans or objectives *based* on the IEP. However, these lesson plans and objectives are not required to be a part of the IEP itself. (See Questions 37-43, below, regarding IEP goals and objectives.)

6. *If a handicapped child has been receiving special education in one LEA and moves to another community, must the new LEA hold an IEP meeting before the child is placed in a special education program?*

It would not be necessary for the new LEA to conduct an IEP meeting if: (1) A copy of the child's current IEP is available; (2) the parents indicate that they are satisfied with the current IEP; and (3) the new LEA determines that the current IEP is appropriate and can be implemented as written.

If the child's current IEP is not available, or if either the LEA or the parent believes that it is not appropriate, an IEP meeting would have to be conducted. This meeting should take place within a short time after the child enrolls in the new LEA (normally, within one week).

Note.—The child must be placed ... special education program immedi... after the IEP is finalized. See Questi... above.

If the LEA or the parents bel... that additional information is ... needed (e.g., the school recor... from the former LEA) or that a ... new evaluation is necessary be... a final placement decision can ... made, it would be permissible ... temporarily place the child in a ... interim program before the IEP ... finalized. (See Question 5, ... above.)

§300.343

Meetings.

(a) *General.* Each public agency is responsible for initiating and conducting meetings for the purpose of developing, reviewing, and revising a handicapped child's individualized education program.

(b) *Handicapped children currently served.* If the public agency has determined that a handicapped child ... receive special education during school year 1977-1978, a meeting must be held early enough to insure th... an individualized education program is developed by October 1, 1977.

(c) *Other handicapped children.* For a handicapped child who is not included under paragraph (b) of this ... action, a meeting must be held within thirty calendar days of a determination that the child needs specia... education and related services.

(d) *Review.* Each public agency shall initiate and conduct meetings to periodically review each child's individualized education program and if appropriate revise its provisions. A meeting must be held for this purpose at least once a year.

(20 U.S.C. 1412 (2) (B), (4), (6), 1414(a) (5).)

Comment. The dates on which agencies must have individualized education programs (IEPs) in effect are specified in §300.342 (October 1, 1977, and the beginning of each school year thereafter). However, except for new handicapped children (i.e., those evaluated and determined to need special education after October 1, 1977), the timing of meetings to develop, review, and revise IEPs is left to the discretion of each agency.

In order to have IEPs in effect by the dates in §300.342, agencies could hold meetings at the end of the school year or during the summer preceding those dates. In meeting the October 1, 1977 timeline, meetings could be conducted up through the October 1 date. Thereafter, meetings may be held any time throughout the year, as long as IEPs are in effect at the beginning of each school year.

The statute requires agencies to hold a meeting at least once each year in order to review, and if appropriate revise, each child's IEP. The timing of those meetings could be on the anniversary date of the last IEP meeting on the child, but this is left to the discretion of the agency.

7. *What is the purpose of the 30 day timeline in Section 300.343(c)?*

The 30 day timeline in §300.343(c) ensures that there will not be a significant delay between the time a child is evaluated and when the child begins to receive special education. Once it is determined—through the evaluation—that a child is handicapped, the public agency has *up to* 30 days to hold an IEP meeting.

Note.—See Questions 4 and 5, above, regarding finalization of IEP and placement of the child.

8. *Must the agency hold a separate meeting to determine a child's eligibility for special education and related services, or can this step be combined with the IEP meeting?*

Paragraph (e) of §300.532 *(Evaluation procedures)* provides that the evaluation of each handicapped child must be "made by a multidisciplinary team or group of persons * * *". The decisions regarding (1) whether the team members actually meet together, and (2) whether such meetings are separate from the IEP meeting, are matters that are left to the discretion of State or local agencies.

In practice, some agencies hold separate eligibility meetings with the multidisciplinary team before the IEP meeting.

Note.—When separate meetings are conducted, placement decisions would be made at the IEP meeting. However, placement options could be discussed at the eligibility meeting.

Other agencies combine the two steps into one. If a combined meeting is conducted, the public agency must include the parents as participants at the meeting. (See §300.345 for requirements on parent participation.)

Note.—If, at a separate eligibility meeting, a decision is made that a child is *not* eligible for special education, the parents should be notified about the decision.

9. *Must IEPs be reviewed or revised at the beginning of each school year?*

No. The basic requirement in the regulations is that IEPs must *be in effect* at the beginning of each school year. Meetings must be conducted at least once each year to review and, if necessary, revise each handicapped child's IEP. However, the meetings may be held anytime during the year, including (1) at the end of the school year, (2) during the summer, before the new school year begins, or (3) on the anniversary date of the last IEP meeting on the child.

10. *How frequently must IEP meetings be held and how long should they be?*

Section 614(a)(5) of the Act provides that each public agency must hold meetings periodically, but not less than annually, to review each child's IEP and, if appropriate, revise its provisions. The legislative history of the Act makes it clear that there should be as many meetings a year as any one child may need. (121 Cong. Rec. S20428–29) (Nov. 19, 1975) (remarks of Senator Stafford))

There is no prescribed length for IEP meetings. In general, meetings (1) will be longer for initial placements and for children who require a variety of complex services, and (2) will be shorter for continuing placements and for children who require only a minimum amount of services. In any event, however, it is expected that agencies will allow sufficient time at the meetings to ensure meaningful parent participation.

11. *Who can initiate IEP meetings?*

IEP meetings are initiated and conducted at the discretion of the public agency. However, if the parents of a handicapped child believe that the child is not progressing satisfactorily or that there is a problem with the child's current IEP, it would be appropriate for the parents to request an IEP meeting. The public agency should grant any reasonable request for such a meeting.

Note.—Under §300.506(a), the parents or agency may initiate a due process hearing at any time regarding any matter related to the child's IEP.

If a child's teacher(s) feels that the child's placement or IEP services are not appropriate to the child, the teacher(s) should follow agency procedures with respect to (1) calling or meeting with the parents and/or (2) requesting the agency to hold another meeting to review the child's IEP.

12. *May IEP meetings be tape-recorded?*

The use of tape recorders at IEP meetings is not addressed by either the Act or the regulations. Although taping is clearly not required, it is permissible at the option of either the parents or the agency. However, if the recording is maintained by the agency, it is an "educational record", within the meaning of the Family Educational Rights and Privacy Act ("FERPA"; 20 U.S.C. 1232g), and would, therefore, be subject to the confidentiality requirements of the regulations under both FERPA (34 CFR Part 99) and EHA-B (34 CFR 300.560–.565).

---

§300.344

Participants in meetings.

(a) *General.* The public agency shall insure that each meeting includes the following participants:

(1) A representative of the public agency, other than the child's teacher, who is qualified to provide, or supervise the provision of, special education.

(2) The child's teacher.

(3) One or both of the child's parents, subject to §300.345.

(4) The child, where appropriate.

(5) Other individuals at the discretion of the parent or agency.

(b) *Evaluation personnel.* For a handicapped child who has been evaluated for the first time, the public agency shall insure:

(1) That a member of the evaluation team participates in the meeting; or

(2) That the representative of the public agency, the child's teacher, or some other person is present at the meeting, who is knowledgeable about the evaluation procedures used with the child and is familiar with the results of the evaluation.

(20 U.S.C. 1401(19); 1412 (2) (B), (4), (6); 1414(a) (5).)

Comment. 1. In deciding which teacher will participate in meetings on a child's individualized education program, the agency may wish to consider the following possibilities.

(a) For a handicapped child who is receiving special education, the "teacher" could be the child's special

education teacher. If the child's handicap is a speech impairment, the "teacher" could be the speech-language pathologist.

(b) For a handicapped child who is being considered for placement in special education, the "teacher" could be the child's regular teacher, or a teacher qualified to provide education in the type of program in which the child may be placed, or both.

(c) If the child is not in school or has more than one teacher, the agency may designate which teacher will participate in the meeting.

2. Either the teacher or the agency representative should be qualified in the area of the child's suspected disability.

3. For a child whose primary handicap is a speech impairment, the evaluation personnel participating under paragraph (b)(1) of this section would normally be the speech-language pathologist.

---

13. *Who can serve as the "representative of the public agency" at an IEP meeting?*

The "representative of the public agency" could be any member of the school staff, other than the child's teacher, who is "qualified to provide, or supervise the provision of, specially designed instruction to meet the unique needs of handicapped children." (Section 602(19) of the Act.) Thus, the agency representative could be (1) a qualified special education administrator, supervisor, or teacher (including a speech-language pathologist), or (2) a school principal or other administrator—if the person is qualified to provide, or supervise the provision of, special education.

Each State or local agency may determine which specific staff member will serve as the agency representative. However, the representative should be able to ensure that whatever services are set out in the IEP will actually be provided and that the IEP will not be vetoed at a higher administrative level within the agency. Thus, the person selected should have the authority to commit agency resources (i.e., to make decisions about the specific special education and related services that the agency will provide to a particular child).

For a handicapped child who requires only a limited amount of special education, the agency representative able to commit appropriate resources could be a special education teacher, or a speech-language pathologist, other than the child's teacher. For a child who requires extensive special education and related services, the agency representative might need to be a key administrator in the agency.

Note.—IEP meetings for continuing placements could be more routine than those for initial placements, and, thus, might not require the participation of a key administrator.

14. *Who is the "representative of the public agency" if a handicapped child is served by a public agency other than the SEA or LEA?*

The answer depends on which agency is responsible, under State law, policy, or practice, for any one or all of the following: (1) The child's education, (2) placing the child, and (3) providing (or paying for the provision of) special education and related services to the child.

In general, the agency representative at the IEP meeting would be a member of the agency or institution that is responsible for the child's education. For example, if a State agency (1) places a child in an institution, (2) is responsible under State law for the child's education, and (3) has a qualified special education staff at the institution, then a member of the institution's staff would be the agency representative at the IEP meetings.

Sometimes there is no special education staff at the institution, and the children are served by special education personnel from the LEA where the institution is located. In this situation, a member of the LEA staff would usually serve as the agency representative.

Note.—In situations where the LEA places a child in an institution, paragraph "b" of the response to Question 1, above, would apply.

15. *For a handicapped child being considered for initial placement in special education, which teacher should attend the IEP meeting?*

The teacher could be either (1) a teacher qualified to provide special education in the child's area of suspected disability, or (2) the child's regular teacher. At the option of the agency, both teachers could attend. In any event, there should be at least one member of the school staff at the meeting (e.g., the agency representative or the teacher) who is qualified in the child's area of suspected disability.

Note.—Sometimes more than one meeting is necessary in order to finalize a child's IEP. If, in this process, the special education teacher who will be working with the child is identified, it would be useful to have that teacher participate in the meeting with the parents and other members of the IEP team in finalizing the IEP. When this is not possible, the agency should ensure that the teacher is given a copy of the child's IEP as soon as possible after the IEP is finalized and before the teacher begins working with the child.

16. *If a handicapped child is enrolled in both regular and special education classes, which teacher should attend the IEP meeting?*

In general, the teacher at the IEP meeting should be the child's special education teacher. At the option of the agency or the parent, the child's regular teacher also might attend. If the regular teacher does not attend, the agency should either provide the regular teacher with a copy of the IEP or inform the regular teacher

of its contents. Moreover, the agency should ensure that the special education teacher, or other appropriate support person, is able, where necessary, to consult with and be a resource to the child's regular teacher.

17. *If a handicapped child in high school attends several regular classes, must all of the child's regular teachers attend the IEP meeting?*

No. Only one teacher must attend. However, at the option of the LEA, additional teachers of the child may attend. The following points should be considered in making this decision:

a. Generally, the number of participants at IEP meetings should be small. Small meetings have several advantages over large ones. For example, they (1) allow for more open, active parent involvement, (2) are less costly, (3) are easier to arrange and conduct, and (4) are usually more productive.

Note.—In an informal examination of IEPs from five States, Department staff found that, on the average, IEP meetings were attended by four persons.

b. While large meetings are generally inappropriate, there may be specific circumstances in which the participation of additional staff would be beneficial. When the participation of the regular teachers is considered by the agency or the parents to be beneficial to the child's success in school (e.g., in terms of the child's participation in the regular education program), it would be appropriate for them to attend the meeting.

c. Although the child's regular teachers would not routinely attend IEP meetings, they should either (1) be informed about the child's IEP by the special education teacher or agency representative, and/or (2) receive a copy of the IEP itself.

18. *If a child's primary handicap is a speech impairment, must the child's regular teacher attend the IEP meeting?*

No. A speech-language pathologist would usually serve as the child's "teacher" for purposes of the IEP meeting. The regular teacher could also attend at the option of the school.

19. *If a child is enrolled in a special education class because of a primary handicap, and also receives speech-language pathology services, must both specialists attend the IEP meeting?*

No. It is not required that both attend. The special education teacher would attend the meeting as the child's "teacher". The speech-language pathologist could either (1) participate in the meeting itself, or (2) provide a written recommendation concerning the nature, frequency, and amount of services to be provided to the child.

20. *When may representatives of teacher organizations attend IEP meetings?*

Under the Family Educational Rights and Privacy Act ("FERPA", 20 U.S.C. 1232g) and implementing regulations (34 CFR Part 99), officials of teacher organizations may not attend IEP meetings at which personally identifiable information from the student's education records may be discussed—except with the prior written consent of the parents. (See 34 CFR 99.30(a)(1).)

In addition, EHA-B does not provide for the participation of representatives of teacher organizations at IEP meetings. The legislative history of the Act makes it clear that attendance at IEP meetings should be limited to those who have an intense interest in the child. (121 Cong. Rec. S10974 (June 18, 1975) (remarks of Sen. Randolph).) Since a representative of a teacher organization would be concerned with the interests of the teacher rather than the interests of the child, it would be inappropriate for such an official to attend an IEP meeting.

21. *When may a handicapped child attend an IEP meeting?*

Generally, a handicapped child should attend the IEP meeting whenever the parent decides that it is appropriate for the child to do so. Whenever possible, the agency and parents should discuss the appropriateness of the child's participation before a decision is made, in order to help the parents determine whether or not the child's attendance will be (1) helpful in developing the IEP and/or (2) directly beneficial to the child. The agency should inform the parents before each IEP meeting—as part of the "notice of meeting" required under § 300.345(b)—that they may invite their child to participate.

Note.—The parents and agency should encourage older handicapped children (particular those at the secondary school level) to participate in their IEP meeting.

22. *Do the parents of a handicapped student retain the right to attend the IEP meeting when the student reaches the age of majority?*

The Act is silent concerning any modification of the rights of a handicapped student's parents when the student reaches the age of majority. The Department is considering providing further guidance on this issue in a separate document.

23. *Must related services personnel attend IEP meetings?*

No. It is not required that they attend. However, if a handicapped child has an identified need for related services, it would be appropriate for the related services personnel to attend the meeting or otherwise be involved in developing the IEP. For example, when the child's evaluation indicates the need for a specific related service (e.g., physical therapy, occupational therapy, or counseling), the agency should ensure that a qualified provider of that service either (1) attends the IEP meeting, or (2) provides a written recommendation concerning the nature, frequency, and amount of service to be provided to the child.

Note.—This written recommendation could be a part of the evaluation report.

24. *Are agencies required to use a case manager in the development of a handicapped child's IEP?*

No. However, some agencies have found it helpful to have a special educator or some other school staff member (e.g., a social worker, counselor, or psychologist) serve as coordinator or case manager of the IEP process for an individual child or for all handicapped children served by the agency. Examples of the kinds of activities which case managers might carry out are (1) coordinating the multidisciplinary evaluation; (2) collecting and synthesizing the evaluation reports and other relevant information about a child that might be needed at the IEP meeting; (3) communicating with the parents; and (4) participating in, or conducting, the IEP meeting itself.

25. *For a child with a suspected speech impairment, who must represent the evaluation team at the IEP meeting?*

No specific person must represent the evaluation team. However, a speech-language pathologist would normally be the most appropriate representative. For many children whose primary handicap is a speech impairment, there may be no other evaluation personnel involved. The comment following § 300.532 *(Evaluation procedures)* states:

Children who have a speech impairment as their primary handicap may not need a complete battery of assessments (e.g., psychological, physical, or adaptive behavior). However, a qualified speech-language pathologist would (1) evaluate each speech impaired child using procedures that are appropriate for the diagnosis and appraisal of speech and language disorders, and (2) where necessary, make referrals for additional assessments needed to make an appropriate placement decision.

---

§300.345

Parent Participation

(a) Each public agency shall take steps to insure that one or both of the parents of the handicapped child are present at each meeting or are afforded the opportunity to participate, including:

(1) Notifying parents of the meeting early enough to insure that they will have an opportunity to attend; and

(2) Scheduling the meeting at a mutually agreed on time and place

(b) The notice under paragraph (a) (1) of this section must indicate the purpose, time, and location of the meeting, and who will be in attendance.

(c) If neither parent can attend, the public agency shall use other methods to insure parent participation, including individual or conference telephone calls.

(d) A meeting may be conducted without a parent in attendance if the public agency is unable to convince the parents that they should attend. In this case the public agency must have a record of its attempts to arrange a mutually agreed on time and place such as:

(1) Detailed records of telephone calls made or attempted and the results of those calls.

(2) Copies of correspondence sent to the parents and any responses received, and

(3) Detailed records of visits made to the parent's home or place of employment and the results of those visits.

(e) the public agency shall take whatever action is necessary to insure that the parent understands the proceedings at a meeting, including arranging for an interpreter for parents who are deaf or whose native language is other than English.

(f) The public agency shall give the parent, on request, a copy of the individualized education program. *(20 U.S.C. 1401(19); 1412 (2)(B), (4), (6); 1414(a)(5).)*

Comment. The notice in paragraph (a) could also inform parents that they may bring other people to the meeting. As indicated in paragraph (c), the procedure used to notify parents (whether oral or written or both) is left to the discretion of the agency, but the agency must keep a record of its efforts to contact parents.

---

26. *What is the role of the parents at an IEP meeting?*

The parents of a handicapped child are expected to be equal participants along with school personnel, in developing, reviewing, and revising the child's IEP. This is an active role in which the parents (1) participate in the discussion about the child's need for special education and related services and (2) join with the other participants in deciding what services the agency will provide to the child.

Note.—In some instances, parents might elect to bring another participant to the meeting, (e.g., a friend or neighbor, someone outside of the agency who is familiar with applicable laws and with the child's needs, or a specialist who conducted an independent evaluation of the child.)

27. *What is the role of a surrogate parent at an IEP meeting?*

A surrogate parent is a person appointed to represent the interests of a handicapped child in the educational decision-making process when that child has no other parent representation. The surrogate has all of the rights and responsibilities of a parent under EHA-B. Thus, the surrogate par-

ent is entitled to (1) participate in the child's IEP meeting, (2) see the child's education records, and (3) receive notice, grant consent, and invoke due process to resolve differences. *(See § 399.514, Surrogate parents.)*

28. *Must the public agency let the parents know who will be at the IEP meeting?*

Yes. In notifying parents about the meeting, the agency "must indicate the purpose, time, and location of the meeting, and *who will be in attendance.*" (§ 300.345(b), emphasis added.) Where possible, the agency should give the name and position of each person who will attend. In additon, the agency should inform the parents of their right to bring other participants to the meeting. (See Question 21, above, regarding participation of the child.) It is also appropriate for the agency to ask whether the parents intend to bring a participant to the meeting.

29. *Are parents required to sign IEPs?*

Parent signatures are not required by either the Act or regulations. However, having such signatures is considered by parents, advocates, and public agency personnel to be useful.

Note.—A national survey conducted under contract with the Department indicates that, in practice, most IEPs are signed by parents.

The following are some of the ways in which IEPs signed by parents and/or agency personnel might be used:

a. A signed IEP is one way to document who attended the meeting.

Note.—This is useful for monitoring and compliance purposes.

If signatures are not used, the agency must document attendance in some other way.

b. An IEP signed by the parents is one way to indicate that the parents approved the child's special education program.

Note.—If, after signing, the parents feel that changes are needed in the IEP, it would be appropriate for them to request another meeting. See Question 11, above.

c. An IEP signed by an agency representative provides the parents a signed record of the services that the agency has agreed to provide.

Note.—Even if the school personnel do not sign, the agency still must provide, or ensure the provision of, the services called for in the IEP.

30. *If the parent signs the IEP, does the signature indicate consent for initial placement?*

The parent's signature on the IEP would satisfy the consent requirement concerning initial placement of the child (§ 300.504(b)(1)(ii)) only if the IEP includes a statement on initial placement which meets the definition of "consent" in § 300.500:

"Consent" means that: (a) the parent has been fully informed of all information relevant to the activity for which consent is sought • • •

(b) The parent understands and agrees in writing to the carrying out of the activity for which his or her consent is sought, and the consent describes that activity and lists the records (if any) which will be released and to whom; and

(c) The parent understands that the granting of consent is voluntary • • • and may be revoked at any time.

31. *Do parents have the right to a copy of their child's IEP?*

Yes. Section 300.345(f) states that "the public agency shall give the parent, on request, a copy of the individualized education program." In order that parents may know about this provision, it is recommended that they be informed about it at the IEP meeting and/or receive a copy of the IEP itself a reasonable time following the meeting.

Note.—The National Committee for Citizens in Education reports that in a 1979 survey of approximately 2,500 parents of handicapped children in 46 States, nearly 70% indicated that a completed copy of the IEP had been made available for them to keep.

32. *Must parents be informed at the IEP meeting of their right to appeal?*

If the agency has already informed the parents of their right to appeal, as it is required to do under the prior notice provisions of the regulations (§§ 300.504–300.505), it would not be necessary for the agency to do so again at the IEP meeting.

- Section 300.504(a) of the regulations states that "written notice which meets the requirements under § 300.505 must be given to parents a reasonable time" before the public agency proposes or refuses "to initiate or change the identification, evaluation, or educational placement of the child or the provision of a free appropriate public education to the child."
- Section 300.505(a) states that the notice must include "(1) A full explanation of all procedural safeguards available to parents" under the due process provisions of the regulations (§§ 300.500–300.589).

The IEP meeting serves as a communication vehicle between parents and school personnel, and enables them, as equal participants, to jointly decide upon what the child's needs are, what will be provided, and what the anticipated outcomes may be. If, during the IEP meeting, parents and school staff are unable to reach agreement, the agency should remind the parents that they may seek to resolve their differences through the due process procedures under the Act.

Note.—Section 300.506(a) states that "a parent or public educational agency may initiate a hearing on any matters described in § 300.504(a)(1) and (2)."

Every effort should be made to resolve differences between parents and school staff without resort to a due process hearing (i.e., through voluntary mediation or some other informal step). However, mediation or other informal procedures may not be used to deny or delay a parent's right to a due process hearing. (See

§ 300.506. *Impartial due process hearing.*)

33. *Does the IEP include ways for parents to check the progress of their children?*

In general, the answer is yes. The IEP document is a written record of decisions jointly made by parents and school personnel at the IEP meeting regarding a handicapped child's special education program. That record includes agreed upon items, such as goals and objectives, and the specific special education and related services to be provided to the child.

The goals and objectives in the IEP should be helpful to both parents and school personnel, in a general way, in checking on a child's progress in the special education program. (See Questions 37-43, below, regarding goals and objectives in the IEP.) However, since the IEP is not intended to include the specifics about a child's total educational program that are found in daily, weekly, or monthly instructional plans, parents will often need to obtain more specific, on-going information about the child's progress—through parent-teacher conferences, report cards and other reporting procedures ordinarily used by the agency.

34. *Must IEPs include specific "checkpoint intervals" for parents to confer with teachers and to review or update their children's IEPs?*

No. A handicapped child's IEP is not required to include specific "checkpoint intervals" (i.e., meeting dates) for reviewing the child's progress. However, in individual situations, specific meeting dates could be designated in the IEP, if the parents and school personnel believe that it would be helpful to do so.

Although meeting dates are not required to be set out in the IEP itself, there are specific provisions in the regulations and in this document regarding agency responsibilities in initiating IEP meetings, including the following: (1) Public agencies must hold meetings periodically, but not less than annually, to review, and if appropriate, revise, each child's IEP (§300.343(d)); (2) there should be as many meetings a year as the child needs (see Question 10, above); and (3) agencies should grant any reasonable parental request for an IEP meeting (see Question 11, above).

In addition to the above provisions, it is expected that, through an agency's general reporting procedures for all children in school, there will be specific designated times for parents to review their children's progress (e.g., through periodic parent-teacher conferences, and/or the use of report cards, letters, or other reporting devices).

35. *If the parents and agency are unable to reach agreement at an IEP meeting, what steps should be followed until agreement is reached?*

As a general rule, the agency and parents would agree to an interim course of action for serving the child (i.e., in terms of placement and/or services) to be followed until the area of disagreement over the IEP is resolved. The manner in which this interim measure is developed and agreed to by both parties is left to the discretion of the individual State or local agency. However, if the parents and agency cannot agree on an interim measure, the child's last agreed upon IEP would remain in effect in the areas of disagreement until the disagreement is resolved. The following may be helpful to agencies when there are disagreements.

a. There may be instances where the parents and agency are in agreement about the basic IEP services (e.g., the child's placement and/or the special education services), but disagree about the provision of a particular related service (i.e., whether the service is needed and/or the amount to be provided). In such cases, it is recommended (1) that the IEP be implemented in all areas in which there is agreement; (2) that the document indicate the points of disagreement, and (3) that proce dures be initiated to resolve the disagreement.

b. Sometimes the disagreeme is with the placement or kind of special education to be provided (e.g., one party proposes a self-contained placement, and the other proposes resource room services). In such cases, the agency might, for example, carry out any one or all of the followin steps: (1) Remind the parents tha they may resolve their difference through the due process procedures under EHA-B; (2) work with the parents to develop an interim course of action (in terms of placement and/or services) which both parties can agree to until resolution is reached; and (3) recommend the use of media tion, or some other informal pro cedure for resolving the differences without going to a due pro cess hearing. (See Question 32, above, regarding the right to appeal.)

c. If, because of the disagreement over the IEP, a hearing is initiated by either the parents or agency, the agency may not change the child's placement unless the parents and agency agree otherwise. (See §300.513, *Child's status during proceedings*.) The following two examples are related to this requirement:

(1) A child in the regular fourth grade has been evaluated and found to be eligible for special education. The agency and parents agree that the child has a specific learning disability. However, one party proposes placement in a self-contained program and the other proposes placemen in a resource room. Agreement cannot be reached, and a due process hearing is initiated. Unless the parents and agency agree otherwise, the child would remai in the regular fourth grade until the issue is resolved.

On the other hand, since the child's need for special educatio is not in question, both parties might agree— as an interim measure—(1) to temporarily place the

child in either one of the programs proposed at the meeting (self-contained program or resource room), or (2) to serve the child through some other temporary agreement.

(2) A handicapped child is currently receiving special education under an existing IEP. A due process hearing has been initiated regarding an alternative special education placement for the child. Unless the parents and agency agree otherwise, the child would remain in the current placement. In this situation, the child's IEP could be revised, as necessary, and implemented in all of the areas agreed to by the parents and agency, while the area of disagreement (i.e., the child's placement) is being settled through due process.

Note.—If the due process hearing concerns whether or not a particular service should continue to be provided under the IEP (e.g., physical therapy), that service *would* continue to be provided to the child under the IEP that was in effect at the time the hearing was initiated, (1) unless the parents and agency agree to a change in the services, or (2) until the issue is resolved.

---

§300.346

Content of individualized education program.

The individualized education program for each child must include:

(a) A statement of the child's present levels of educational performance;

(b) A statement of annual goals, including short term instructional objectives;

(c) A statement of the specific special education and related services to be provided to the child, and the extent to which the child will be able to participate in regular educational programs;

(d) The projected dates for initiation of services and the anticipated duration of the services; and

(e) Appropriate objective criteria and evaluation procedures and schedules for determining, on at least an annual basis, whether the short term instructional objectives are being achieved.

(20 U.S.C. 1401(19); 1412 (2)(B), (4), (6); 1414(a)(5); Senate Report No. 94-168, p. 11 (1975).)

---

36. *What should be included in the statement of the child's present levels of educational performance?*

The statement of present levels of educational performance will be different for each handicapped child. Thus, determinations about the content of the statement for an individual child are matters that are left to the discretion of participants in the IEP meetings. However, the following are some points which should be taken into account in writing this part of the IEP:

a. The statement should accurately describe the effect of the child's handicap on the child's performance in any area of education that is affected, including (1) academic areas (reading, math, communication, etc.), and (2) non-academic areas (daily life activities, mobility, etc.).

Note.—Labels such as "mentally retarded" or "deaf" may not be used as a substitute for the description of present levels of educational performance.

b. The statement should be written in objective measurable terms, to the extent possible. Data from the child's evaluation would be a good source of such information. Test scores that are pertinent to the child's diagnosis might be included, where appropriate. However, the scores should be (1) self-explanatory (i.e., they can be interpreted by all participants without the use of test manuals or other aids), or (2) an explanation should be included. Whatever test results are used should reflect the impact of the handicap on the child's performance. Thus, raw scores would not usually be sufficient.

c. There should be a direct relationship between the present levels of educational performance and the other components of the IEP. Thus, if the statement describes a problem with the child's reading level and points to a deficiency in a specific reading skill, this problem should be addressed under both (1) goals and objectives, and (2) specific special education and related services to be provided to the child.

37. *Why are goals and objectives required in the IEP?*

The statutory requirements for including annual goals and short term objectives (Section 602(19)(B)), and for having at least an annual review of a handicapped child's IEP (Section 614(a)(5)), provide a mechanism for determining (1) whether the anticipated outcomes for the child are being met (i.e., whether the child is progressing in the special education program) and (2) whether the placement and services are appropriate to the child's special learning needs. In effect, these requirements provide a way for the child's teacher(s) and parents to be able to track the child's progress in special education. However, the goals and objectives in the IEP are not intended to be as specific as the goals and objectives that are normally found in daily, weekly, or monthly instructional plans.

38. *What are "annual goals" in an IEP?*

The annual goals in the IEP are statements which describe what a handicapped child can reasonably be expected to accomplish within a twelve month period in the child's special education program. As indicated under Question 36, above, there should be a direct relationship between the annual goals and the present levels of educational performance.

39. *What are "short term instructional objectives" in an IEP?*

"Short term instructional objectives" (also called "IEP objectives") are measurable, intermediate steps between a handicapped child's present levels of educational performance and the annual goals that are established for the child. The objectives are developed based on a logical breakdown of the major components of the annual goals, and can serve as milestones for measuring progress toward meeting the goals.

In some respects, IEP objectives are similar to objectives used in daily classroom instructional plans. For example, both kinds of objectives are used (1) to describe what a given child is expected to accomplish in a particular area within some specified time period, and (2) to determine the extent to which the child is progressing toward those accomplishments.

In other respects, objectives in IEPs are different from those used in instructional plans, primarily in the amount of detail they provide. IEP objectives provide general benchmarks for determining progress toward meeting the annual goals. These objectives should be projected to be accomplished over an extended period of time (e.g., an entire school quarter or semester). On the other hand, the objectives in classroom instructional plans deal with more specific outcomes that are to be accomplished on a daily, weekly, or monthly basis. Classroom instructional plans generally include details not required in an IEP, such as the specific methods, activities, and materials (e.g., use of flash cards) that will be used in accomplishing the objectives.

40. *Should the IEP goals and objectives focus only on special education and related services, or should they relate to the total education of the child?*

IEP goals and objectives are concerned primarily with meeting a handicapped child's need for special education and related services, and are not required to cover all aspects of the child's education. Stated another way, the goals and objectives in the IEP should focus on offsetting or reducing the problems resulting from the child's handicap which interfere with learning and educational performance in school. For example, if a learning disabled child is functioning several grades below the child's indicated ability in reading and has a specific problem with word recognition, the IEP goals and objectives would be directed toward (1) closing the gap between the child's indicated ability and current level of functioning, and (2) helping the child increase the ability to use word attack skills effectively (or to find some other approach to increase independence in reading).

For a child with a mild speech impairment, the IEP objectives would focus on improving the child's communication skills, by either (1) correcting the impairment, or (2) minimizing its effect on the child's ability to communicate. On the other hand, the goals and objectives for a severely retarded child would be more comprehensive and cover more of the child's school program than if the child has only a mild handicap.

41. *Should there be a relationship between the goals and objectives in the IEP and those that are in instructional plans of special education programs?*

Yes. There should be a direct relationship between the IEP goals and objectives for a given handicapped child and the goals and objectives that are in the special education instructional plans for the child. However, the IEP is not intended to be detailed enough to be used as an instructional plan. The IEP, through its goals and objectives, (1) sets the general direction to be taken by those who will implement the IEP, and (2) serves as the basis for developing a detailed instructional plan for the child.

Note.—See Question 56, below, regarding the length of IEPs.

42. *When must IEP objectives be written—before placement or after placement?*

IEP objectives must be written before placement. Once a handicapped child is placed in a special education program, the teacher might develop lesson plans or more detailed objectives *based* on the IEP; however, such plans and objectives are not required to be a part of the IEP itself.

43. *Can short term instructional objectives be changed without initiating another IEP meeting?*

No. Section 300.343(a) provides that the agency "is responsible for initiating and conducting meetings for the purpose of developing, reviewing, and *revising* a handicapped child's individualized education program" (emphasis added). Since a change in short term instructional objectives constitutes a revision of the child's IEP, the agency must (1) notify the parents of the proposed change (see §300.504(a)(1)), and (2) initiate an IEP meeting. Note, however, that if the parents are unable or unwilling to attend such a meeting, their participation in the revision of the IEP objectives can be obtained through other means, including individual or conference telephone calls (see §300.345(c)).

44. *Must the IEP include all special education and related services needed by the child or only those available from the public agency?*

Each public agency must provide a free appropriate public education to all handicapped children under its jurisdiction. Therefore, the IEP for a handicapped child must include all of the specific education and related services needed by the child—as determined by the child's current evaluation. This means that the services must be listed in the IEP even if they are not directly available from the local agency, and must be provided by the agency through contract or other arrangements.

45. *Is the IEP a commitment to provide services—i.e., must a public*

agency provide all of the services listed in the IEP?

Yes. Each handicapped child's IEP must include all services necessary to meet the child's identified special education and related services needs, and all services in the IEP must be provided in order for the agency to be in compliance with the Act.

46. *Must the public agency itself directly provide the services set out in the IEP?*

The public agency responsible for the education of a handicapped child could provide IEP services to the child (1) directly, through the agency's own staff resources, or (2) indirectly, by contracting with another public or private agency, or through other arrangements. In providing the services, the agency may use whatever State, local, Federal, and private sources of support are available for those purposes (see §300.301(a)). However, the services must be at no cost to the parents, and responsibility for ensuring that the IEP services are provided remains with the public agency.

47. *Does the IEP include only the special education and related services or does it describe the total education of the child?*

The IEP is required to include only those matters concerning the provision of special education and related services and the extent to which the child can participate in regular education programs.

Note.—The regulations define "special education" as specially designed instruction to meet the unique needs of a handicapped child, and "related services" as those which are necessary to assist a child to benefit from special education (see §§ 300.14 and 300.13, respectively).

For some handicapped children, the IEP will only address a very limited part of their education (e.g., for a speech impaired child the IEP would generally be limited to the child's speech impairment; for other children (e.g., those who are profoundly retarded) the IEP might cover their total education. An IEP for a physically impaired child with no mental impairment might consist only of specially designed physical education. However, if the child also has a mental impairment, the IEP might cover most of the child's education.

Note.—The IEP is not intended to be detailed enough to be used as an instructional plan. See Question 41, above.

48. *If modifications are necessary for a handicapped child to participate in a regular education program, must they be included in the IEP?*

Yes. If modifications (supplementary aids and services) to the regular education program are necessary to ensure the child's participation in that program, those modifications must be described in the child's IEP (e.g., for a hearing impaired child, special seating arrangements or the provision of assignments in writing). This applies to any regular education program in which the student may participate, including physical education, art, music, and vocational education.

49. *When must physical education (PE) be described or referred to in the IEP?*

Section 300.307(a) provides that physical education services, specially designed if necessary, must be made available to every handicapped child receiving a free appropriate public education." The following paragraphs (1) set out some of the different PE program arrangements for handicapped students, and (2) indicate whether, and to what extent, PE must be described or referred to in an IEP.

a. *Regular PE with non-handicapped students.* If a handicapped student can participate fully in the regular PE program without any special modifications to compensate for the student's handicap, it would not be necessary to describe or refer to PE in the IEP. On the other hand, if some modifications to the regular PE program are necessary for the student to be able to participate in that program, those modifications must be described in the IEP.

b. *Specially designed PE.* If a handicapped student needs a specially designed PE program, that program must be addressed in all applicable areas of the IEP (e.g., present levels of educational performance, goals and objectives, and services to be provided). However, these statements would not have to be presented in any more detail than the other special education services included in the student's IEP.

c. *PE in separate facilities.* If a handicapped student is educated in a separate facility, the PE program for that student must be described or referred to in the IEP. However, the kind and amount of information to be included in the IEP would depend on the physical-motor needs of the student and the type of PE program that is to be provided.

Thus, if a student is in a separate facility that has a standard PE program (e.g., a residential school for the deaf), and if it is determined—on the basis of the student's most recent evaluation—that the student is able to participate in that program without any modifications, then the IEP need only note such participation. On the other hand, if special modifications to the PE program are needed for the student to participate, those modifications must be described in the IEP. Moreover, if the student needs an individually designed PE program, that program must be addressed under all applicable parts of the IEP. (See paragraph "b", above.)

Note.—The Department is considering the possibility of publishing a separate document on the PE requirement under the Act and regulations.

50. *If a handicapped student is to receive vocational education, must it be described or referred to in the student's IEP?*

The answer depends on the kind of vocational education program to be provided. If a handicapped student is able to participate in the regular vocational education program without any modifications to compensate for

the student's handicap, it would not be necessary to include vocational education in the student's IEP. On the other hand, if modifications to the regular vocational education program are necessary in order for the student to participate in that program, those modifications must be included in the IEP. Moreover, if the student needs a specially designed vocational education program, then vocational education must be described in all applicable areas of the student's IEP (e.g., present levels of educational performance, goals and objectives, and specific services to be provided). However, these statements would not have to be presented in any more detail than the other special education services included in the IEP.

Note:—Regulations under the Vocational Education Act provide that (1) certain funds available under that Act for vocational programs for handicapped persons must be used in a manner consistent with the State's plan under EHA-B, and (2) the five-year State Vocational Education Plan "shall describe how the program provided each handicapped child will be planned and coordinated in conformity with and as a part of the child's individualized education program as required by the Education of the Handicapped Act." See 34 CFR 400.141(a)(10), 400.182(f) (formerly 45 CFR 104.141(f)(10), 104.182(f)).

51. *Must the IEP specify the amount of services or may it simply list the services to be provided?*

The amount of services to be provided must be stated in the IEP, so that the level of the agency's commitment of resources will be clear to parents and other IEP team members. The amount of time to be committed to each of the various services to be provided must be (1) appropriate to that specific service, and (2) stated in the IEP in a manner that is clear to all who are involved in both the development and implementation of the IEP.

Changes in the amount of services listed in the IEP cannot be made without holding another IEP meeting. However, as long as there is no change in the overall amount, some adjustments in scheduling the services should be possible (based on the professional judgment of the service provider) without holding another IEP meeting.

Note.—The parents should be notified whenever this occurs.

52. *Must a handicapped child's IEP indicate the extent to which the child will be educated in the regular educational program?*

Yes. Section 300.346(c) provides that the IEP for each handicapped child must include a "statement of * * * the extent to which the child will be able to participate in regular educational programs." One way of meeting this requirement is to indicate the percent of time the child will be spending in the regular education program with non-handicapped students. Another way is to list the specific regular education classes the child will be attending.

Note.—If a severely handicapped child, for example, is expected to be in a special classroom setting most of the time, it is recommended that, in meeting the above requirement, the IEP include any non-curricular activities in which the child will be participating with non-handicapped students (e.g., lunch, assembly periods, club activities, and other special events).

53. *Can the anticipated duration of services be for more than twelve months?*

In general, the anticipated duration of services would be up to twelve months. There is a direct relationship between the anticipated duration of services and the other parts of the IEP (e.g., annual goals and short term objectives), and each part of the IEP would be addressed whenever there is a review of the child's program. If it is anticipated that the child will need a particular service for more than one year, the duration of that service could be projected beyond that time in the IEP. However, the duration of each service must be reconsidered whenever the IEP is reviewed.

54. *Must the evaluation procedures and schedules be included as a separate item in the IEP?*

No. The evaluation procedures and schedules need not be included as a separate item in the IEP, but they must be presented in a recognizable form and be clearly linked to the short term objectives.

Note.—In many instances, these components are incorporated directly into the objectives.

Other Questions About the Content of an IEP.

55. *Is it permissible for an agency to have the IEP completed when the IEP meeting begins?*

No. It is not permissible for an agency to present a completed IEP to parents for their approval before there has been a full discussion with the parents of (1) the child's need for special education and related services, and (2) what services the agency will provide to the child. Section 602(9) of the Act defines the IEP as a written statement *developed in any meeting* with the agency representative, the teacher, the parent, and, whenever appropriate, the child.

It would be appropriate for agency staff to come prepared with evaluation findings, statements of present levels of educational performance, and a recommendation regarding annual goals, short term instructional objectives, and the kind of special education and related services to be provided. However, the agency must make it clear to the parents at the outset of the meeting that the services proposed by the agency are only recommendations for review and discussion with the parents. The legislative history of Pub. L. 94-142 makes it clear that parents must be given the opportunity to be active participants in all major decisions affecting the education of their handicapped children. (See, e.g., S. Rep. No. 168, 94th Cong. 1st Sess. 13 (1975), S. Rep. No. 455 (Conference Report), 94th Cong. 1st Sess. 47-50 (1975).)

56. *Is there a prescribed format or length for an IEP?*

No. The format and length of an IEP are matters left to the dis-

cretion of State and local agencies. The IEP should be as long as necessary to adequately describe a child's program. However, as indicated in Question 41, above, the IEP is not intended to be a detailed instructional plan. The Federal IEP requirements can usually be met in a one to three page form.

Note.—In a national survey conducted under contract with the Department, it was found that 47% of the IEPs reviewed were 3 pages or less in length.

57. *Is it permissible to consolidate the IEP with an individualized service plan developed under another Federal program?*

Yes. In instances where a handicapped child must have both an IEP and an individualized service plan under another Federal program, it may be possible to develop a single, consolidated document: *Provided*, That (1) it contains all of the information required in an IEP, and (2) all of the necessary parties participate in its development.

Examples of individualized service plans which might be consolidated with the IEP are: (1) The Individualized Care Plan (Title XIX of the Social Security Act (Medicaid)), (2) the Individualized Program Plan (Title XX of the Social Security Act (Social Services)), (3) the Individualized Service Plan (Title XVI of the Social Security Act (Supplemental Security Income)), and (4) the Individualized Written Rehabilitation Plan (Rehabilitation Act of 1973).

58. *What provisions on confidentiality of information apply to IEPs?*

IEPs are subject to the confidentiality provisions of both (1) EHA-B (Section 617(c) of the Act; §§300.560-300.576 of the regulations), and (2) the Family Educational Rights and Privacy Act ("FERPA", 20 U.S.C. 1232g). An IEP is an "education record" as that term is used in the FERPA and implementing regulations (34 CFR Part 99) and is, therefore, subject to the same protections as other education records relating to the student.

Note.—Under Section 99.31(a) of the FERPA regulations, an educational agency may disclose personally identifiable information from the education records of a student without the written consent of the parents "if the disclosure is—(1) To other school officials, including teachers, within the educational institution or local educational agency who have been determined by the agency or institution to have legitimate educational interests • • • " in that information.

---

§300.347

Private school placements.

(a) *Developing individualized education programs.* (1) Before a public agency places a handicapped child in, or refers a child to a private school or facility, the agency shall initiate and conduct a meeting to develop an individualized education program for the child in accordance with §300.343.

(2) The agency shall insure that a representative of the private school facility attends the meeting. If the representative cannot attend, the agency shall use other methods to insure participation by the private school or facility, including individual or conference telephone calls.

(3) The public agency shall also develop an individualized educational program for each handicapped child who was placed in a private school or facility by the agency before the effective date of these regulations.

(b) *Reviewing and revising individualized education programs.* (1) After a handicapped child enters a private school or facility, any meetings to review and revise the child's individualized education program may be initiated and conducted by the private school or facility at the discretion of the public agency.

(2) If the private school or facility initiates and conducts these meetings, the public agency shall insure that the parents and an agency representative:

(i) Are involved in any decision about the child's individualized education program; and

(ii) Agree to any proposed changes in the program before those changes are implemented.

(c) *Responsibility.* Even if a private school or facility implements a child's individualized education program, responsibility for compliance with this part remains with the public agency and the State educational agency.

(20 U.S.C. 1413(a)(4)(B))

---

§300.348

Handicapped children in parochial or other private schools.

If a handicapped child is enrolled in a parochial or other private school and receives special education or related services from a public agency, the public agency shall:

(a) Initiate and conduct meetings to develop, review, and revise an individualized education program for the child in accordance with §300.343, and

(b) Insure that a representative of the parochial or other private school attends each meeting. If the representative cannot attend, the agency shall use other methods to insure participation by the private school, including individual or conference telephone calls.

(20 U.S.C. 1413(a)(4)(A))

59. *If placement decisions are made at the time the IEP is developed, how can a private school representative attend the meeting?*

Generally, a child who requires placement in either a public or private residential school has already been receiving special education, and the parents and school personnel have often jointly been involved over a prolonged period of time in attempting to find the most appropriate placement for the child. At some point in this process (e.g., at a meeting where the child's current IEP is being reviewed), the possibility of residential school placement might be proposed—by either the parents or school personnel. If both agree, then the matter would be explored with the residential school. A subsequent meeting would then be conducted to finalize the IEP. At this meeting, the public agency must ensure that a representative of the residential school either (1) attends the meeting, or (2) participates through individual or conference telephone calls, or by other means.

Note.—The Department is considering publishing a separate document concerning the education of handicapped children placed in parochial or other private schools by their parents. Questions concerning IEPs for those children would be addressed in that document.

---

§300.349

Individualized education program—accountability.

Each public agency must provide special education and related services to a handicapped child in accordance with an individualized education program. However, Part B of the Act does not require that any agency, teacher, or other person be held accountable if a child does not achieve the growth projected in the annual goals and objectives.

(20 U.S.C. 1412(2)(B); 1414(a)(5), (6); Cong. Rec. at H 7152 (daily ed., July 21, 1975).)

Comment. This section is intended to relieve concerns that the individualized education program constitutes a guarantee by the public agency and the teacher that a child will progress at a specified rate. However, this section does not relieve agencies and teachers from making good faith efforts to assist the child in achieving the objectives and goals listed in the individualized education program. Further, the section does not limit a parent's right to complain and ask for revisions of the child's program, or to invoke due process procedures, if the parent feels that these efforts are not being made.

---

60. *Is the IEP a performance contract?*

No. Section 300.349 makes it clear that the IEP is *not* a performance contract that imposes liability on a teacher or public agency if a handicapped child does not meet the IEP objectives. While the agency must provide special education and related services in accordance with each handicapped child's IEP, the Act does not require that the agency, the teacher, or other persons be held accountable if the child does not achieve the growth projected in the written statement.

"This description comes from the Federal Register, Volume 46, No. 12, January 19, 1981, Rules and Regulations, pp 5462 through 5474. The document was prepared under cooperative agreement G0084C35[illegible] between Interstate Research Associates, 1555 Wilson Boulevard, Rosslyn, VA 22209, and the Department of Education, Office of Special Education and Related Services, Special Education Programs."

National Information Center for
Handicapped Children and Youth
Box 1492
Washington, D.C. 20013